

Childhood Well-care Assessment: 18 months to 12 years

Name:		Date:		
DOB:		Sex:		
Wt:	Ht:	BMI:	T:	BP:

Interval history

Medications:	
Allergies:	
Illnesses/accidents/problems/concerns:	
Diet:	Sleep:
Elimination:	Other:

- | | | |
|---|---|---|
| Review immunization record <input type="checkbox"/> | WIC referral <input type="checkbox"/> | Vitamins <input type="checkbox"/> |
| Review of systems <input type="checkbox"/> | Review of family history <input type="checkbox"/> | Lead-risk assessment <input type="checkbox"/> |
| Dental referral <input type="checkbox"/> | Fluoride supplements <input type="checkbox"/> | Tb test (if high risk) <input type="checkbox"/> |

Screening	Normal/abnormal		Normal/abnormal		Normal/abnormal
Hearing	<input type="checkbox"/> <input type="checkbox"/>	Vision	<input type="checkbox"/> <input type="checkbox"/>	Development	<input type="checkbox"/> <input type="checkbox"/>
Behavior	<input type="checkbox"/> <input type="checkbox"/>	Emotional	<input type="checkbox"/> <input type="checkbox"/>	Communication	<input type="checkbox"/> <input type="checkbox"/>

Physical exam	Normal/abnormal		Normal/abnormal		Normal/abnormal
General appearance	<input type="checkbox"/> <input type="checkbox"/>	Lungs	<input type="checkbox"/> <input type="checkbox"/>	Skin	<input type="checkbox"/> <input type="checkbox"/>
Reflexes	<input type="checkbox"/> <input type="checkbox"/>	Chest	<input type="checkbox"/> <input type="checkbox"/>	Head/fontanel	<input type="checkbox"/> <input type="checkbox"/>
Ears	<input type="checkbox"/> <input type="checkbox"/>	Nose/throat	<input type="checkbox"/> <input type="checkbox"/>	Eyes	<input type="checkbox"/> <input type="checkbox"/>
Teeth	<input type="checkbox"/> <input type="checkbox"/>	Neurological	<input type="checkbox"/> <input type="checkbox"/>	Abdomen	<input type="checkbox"/> <input type="checkbox"/>
Spine	<input type="checkbox"/> <input type="checkbox"/>	Extremities	<input type="checkbox"/> <input type="checkbox"/>	Genitalia	<input type="checkbox"/> <input type="checkbox"/>

If abnormal, explain:

Health education/anticipatory guidance

<input type="checkbox"/>	Nutrition	<input type="checkbox"/>	Regular physical activities	<input type="checkbox"/>	Passive smoke
<input type="checkbox"/>	Appropriate car seat/seatbelt	<input type="checkbox"/>	Language development	<input type="checkbox"/>	Oral health
<input type="checkbox"/>	Developmental	<input type="checkbox"/>	School issues	<input type="checkbox"/>	Childcare issues
<input type="checkbox"/>	Injury prevention	<input type="checkbox"/>	Supervision/safety	<input type="checkbox"/>	Other _____

<https://mediproviders.anthem.com/ky>

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Notes/plans:

Next visit:

Provider signature:
