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 □ WIC referral □ Vitamins □
Review of systems □ Review of family history □ Lead-risk assessment □
Dental referral □ Fluoride supplements □ Tb test (if high risk) □

Screening	Normal/abnormal		Normal/abnormal		Normal/abnormal
Hearing	□ □	Vision	□ □	Development	□ □
Behavior	□ □	Emotional	□ □	Communication	□ □

Physical exam	Normal/abnormal		Normal/abnormal		Normal/abnormal
General appearance	□ □	Lungs	□ □	Skin	□ □
Reflexes	□ □	Chest	□ □	Head/fontanel	□ □
Ears	□ □	Nose/throat	□ □	Eyes	□ □
Teeth	□ □	Neurological	□ □	Abdomen	□ □
Spine	□ □	Extremities	□ □	Genitalia	□ □

If abnormal, explain:
_____
_____

Health education/anticipatory guidance

□	Nutrition	□	Regular physical activities	□	Passive smoke
□	Appropriate car seat/seatbelt	□	Language development	□	Oral health
□	Developmental	□	School issues	□	Childcare issues
□	Injury prevention	□	Supervision/safety	□	Other_____ _____

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Notes/plans:

Next visit: **Provider signature:**