

**Infant Well-care Assessment: Birth to 15 Months**

<b>Name:</b>	<b>Date:</b>
<b>DOB:</b>	<b>Sex:</b>
<b>Wt:</b>	<b>Ht:</b>
	<b>Head cir.:</b>

**Interval history**

**Medications:**

**Allergies:**

**Illnesses/accidents/problems/concerns:**

**Diet:** **Sleep:**

**Elimination:** **Other:**

- Review immunization record  WIC referral  Vitamins
- Review of systems  Review of family and birth history  Lead-risk assessment
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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"/>	Gross motor	<input type="checkbox"/> <input type="checkbox"/>	Fine motor	<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:

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**Health education/anticipatory guidance**

<input type="checkbox"/>	No bottle in bed	<input type="checkbox"/>	Sleeping on back	<input type="checkbox"/>	Passive smoke
<input type="checkbox"/>	Appropriate car seat	<input type="checkbox"/>	Language development	<input type="checkbox"/>	Oral health
<input type="checkbox"/>	Developmental benchmarks	<input type="checkbox"/>	Fever protocols	<input type="checkbox"/>	Childcare issues
				<input type="checkbox"/>	Safety
<input type="checkbox"/>	Bedtime rituals	<input type="checkbox"/>	Lead-poisoning prevention	<input type="checkbox"/>	Other _____

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

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**Notes/plans:**

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**Next visit:**

**Provider signature:**

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