

Childhood Well-care Assessment

18 months to 12 years

[Not for use in Tennessee.]



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/seat belt	<input type="checkbox"/>	Language development	<input type="checkbox"/>	Oral health
<input type="checkbox"/>	Developmental	<input type="checkbox"/>	School issues	<input type="checkbox"/>	Child care issues
<input type="checkbox"/>	Injury prevention	<input type="checkbox"/>	Supervision/safety	<input type="checkbox"/>	Other _____

Notes/plans: _____

Next visit: _____ Provider signature: _____