Infant Well-care Assessment
Birth to 15 months

[Not for use in Tennessee.]

Name: **Date:**

DOB: **Sex:**

Wt: **Ht:** **Head cir.:**

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 ❒

Screening	Normal/abnormal		Normal/abnormal		Normal/abnormal
Hearing	❒ ❒	Vision	❒ ❒	Development	❒ ❒
Behavior	❒ ❒	Gross motor	❒ ❒	Fine motor	❒ ❒

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

❒	No bottle in bed	❒	Sleeping on back	❒	Passive smoke
❒	Appropriate car seat	❒	Language development	❒	Oral health
❒	Developmental benchmarks	❒	Fever protocols	❒	Child care issues
				❒	Safety
❒	Bedtime rituals	❒	Lead-poisoning prevention	❒	Other ________

Notes/plans:

Next visit: **Provider signature:**