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DATE:	10 MONTHS	DATE:	12 MONTHS	DATE:	15 MONTHS
AGE: _____	WEIGHT: _____	TEMP.: _____	AGE: _____	WEIGHT: _____	TEMP.: _____
LENGTH: _____	HEAD: _____	LENGTH: _____	HEAD: _____	LENGTH: _____	HEAD: _____
<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>	
<u>DIET</u>		<u>DIET</u>		<u>DIET</u>	
<u>DEVELOPMENT</u> 1. Pulls self to stand _____ 2. Stands holding on _____ 3. Dada Mama _____ 4. Thumb-finger grasp _____		<u>DEVELOPMENT</u> 1. Stands momentarily _____ 2. Walks holding (furniture) _____ 3. Bangs two cubes _____ 4. Plays pat-a-cake _____		<u>DEVELOPMENT</u> 1. Walks well _____ 2. Cup - little spillage _____ 3. Dada, Mama (specific) _____ 4. Indicates wants by pointing, pulling (not crying) _____	
<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities	
Gen.App.	<input type="checkbox"/>	Gen.App.	<input type="checkbox"/>	Gen.App.	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Skin	<input type="checkbox"/>	Skin	<input type="checkbox"/>
Head	<input type="checkbox"/>	Head	<input type="checkbox"/>	Head	<input type="checkbox"/>
Nodes	<input type="checkbox"/>	Nodes	<input type="checkbox"/>	Nodes	<input type="checkbox"/>
ENT	<input type="checkbox"/>	ENT	<input type="checkbox"/>	ENT	<input type="checkbox"/>
Chest	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Chest	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Lungs	<input type="checkbox"/>
Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>
Abdom.	<input type="checkbox"/>	Abdom.	<input type="checkbox"/>	Abdom.	<input type="checkbox"/>
Ext.Gen.	<input type="checkbox"/>	Ext.Gen.	<input type="checkbox"/>	Ext.Gen.	<input type="checkbox"/>
Back	<input type="checkbox"/>	Back	<input type="checkbox"/>	Back	<input type="checkbox"/>
Extrem.	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>
Neurol.	<input type="checkbox"/>	Neurol.	<input type="checkbox"/>	Neurol.	<input type="checkbox"/>
<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>	
<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>	
<u>TEACHING</u> 1. Diet: Table foods, finger-foods, whole milk 2. Accidents: Especially poisons 3. Independence-dependency 4. Affection/Discipline Appointment to next Clinic _____ Signature: _____		<u>TEACHING</u> 1. Weaning 2. Finger foods 3. Getting into things 4. Normal drop in appetite 5. Accidents: Climbing burns Appointment to next Clinic _____ Signature: _____		<u>TEACHING</u> 1. 'No!' is emerging 2. Temper tantrums 3. Discipline-obedience 4. Avoid constant 'no-no' 5. Accidents 6. Review of gastroenteritis, obesity & anemia Appointment to next Clinic _____ Signature: _____	

ADDRESSOGRAPH

**WELL BABY CLINIC
10-15 MONTHS**

IHS-5-4
(1/89)

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DATE:	18 MONTHS	DATE:	21 MONTHS	DATE:	24 MONTHS
AGE: _____	WEIGHT: _____	TEMP.: _____	AGE: _____	WEIGHT: _____	TEMP.: _____
LENGTH: _____	HEAD: _____	LENGTH: _____	HEAD: _____	LENGTH: _____	HEAD: _____
<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>		<u>INTERVAL HISTORY</u>	
<u>DIET</u>		<u>DIET</u>		<u>DIET</u>	
<u>DEVELOPMENT</u> 1. Mimics household chores, like dusting, sweeping _____ 2. Piles two blocks _____		<u>DEVELOPMENT</u> 1. Can remove clothing _____ 2. Uses spoon _____ 3. Walks backwards & up steps _____		<u>DEVELOPMENT</u> 1. Kicks ball _____ 2. Points to body part _____ 3. Simple household tasks _____ 4. Momma, Dada, 3 words _____	
<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities		<u>PHYSICAL EXAMINATION</u> Abnormalities	
Gen.App.	<input type="checkbox"/>	Gen.App.	<input type="checkbox"/>	Gen.App.	<input type="checkbox"/>
Skin	<input type="checkbox"/>	Skin	<input type="checkbox"/>	Skin	<input type="checkbox"/>
Head	<input type="checkbox"/>	Head	<input type="checkbox"/>	Head	<input type="checkbox"/>
Nodes	<input type="checkbox"/>	Nodes	<input type="checkbox"/>	Nodes	<input type="checkbox"/>
ENT	<input type="checkbox"/>	ENT	<input type="checkbox"/>	ENT	<input type="checkbox"/>
Chest	<input type="checkbox"/>	Chest	<input type="checkbox"/>	Chest	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	Lungs	<input type="checkbox"/>
Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>	Heart	<input type="checkbox"/>
Abdom.	<input type="checkbox"/>	Abdom.	<input type="checkbox"/>	Abdom.	<input type="checkbox"/>
Ext.Gen.	<input type="checkbox"/>	Ext.Gen.	<input type="checkbox"/>	Ext.Gen.	<input type="checkbox"/>
Back	<input type="checkbox"/>	Back	<input type="checkbox"/>	Back	<input type="checkbox"/>
Extrem.	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>	Extrem.	<input type="checkbox"/>
Neurol.	<input type="checkbox"/>	Neurol.	<input type="checkbox"/>	Neurol.	<input type="checkbox"/>
<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>		<u>PROBLEMS (with plans/referrals)</u>	
<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>		<u>IMMUNIZATIONS</u>	
<u>TEACHING</u> 1. Siblings-jealousy 2. Speech 3. Toilet training 4. Dental care Appointment to next Clinic _____ Signature: _____		<u>TEACHING</u> 1. Poor appetite 2. Ceaseless activity, short attention span 3. Negativism, easy frustration 4. Mother needs free time Appointment to next Clinic _____ Signature: _____		<u>TEACHING</u> 1. Need for playmates 2. Inability to share 3. Sibling adjustment 4. Accidents 5. Avoids junk foods Appointment to next Clinic _____ Signature: _____	

ADDRESSOGRAPH

**WELL BABY CLINIC
18-24 MONTHS**

IHS-5-4 (BACK)
(1/89)