



Recommendations for Preventive Pediatric Health Care

Northwest Primary Care recommends that you bring your child in for regular visits to assist in keeping your child healthy. Well-child visits allow your child’s Primary Care Provider (PCP) to monitor your child’s growth and development, give any vaccines that are due, and provide a chance to find and treat any concerns early. Well-child appointments are also a good time for you to ask any questions that you have about your child’s health and also give the PCP time to discuss age appropriate behavioral issues, including behaviors at the adolescent age.

Visit and Immunization chart

This chart lists important vaccines and tests as well as recommended well-child visits. In addition to these vaccinations, we recommend all children aged 6 months and older get a flu vaccine every fall.

AGE	Recommended office visits	Pediatric routine visit schedule
Birth	Well-child visit	Newborn blood screen Immunizations may be due
3-5 days	Well-child visit	
7-14 days	Well-child visit	2 nd PKU will be due (please bring in baby’s paperwork)
1 month	Well-child visit	Height, weight and head circumference check for proper growth
2 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
4 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
6 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due
9 months	Well-child visit	Height, weight and head circumference check for proper growth Developmental screening
12 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Developmental screening and blood draw
15-18 months	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Developmental and Autism screening
2 years	Well-child visit	Height, weight and head circumference check for proper growth Immunizations may be due Autism screening, blood draw and BMI check
3 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
4 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure, vision and hearing check
5 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure, vision and hearing check
6, 8 and 10 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
11 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure and vision check
12 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
13 years	Well-child visit	Height and weight check for proper growth Immunizations may be due BMI, blood pressure and vision check
14 and 15 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
16 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check
17 years	Well-child visit	Height and weight check for proper growth BMI, blood pressure and vision check



12 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB: _____ Male Female

Physician Signature: _____

Instructions: Please answer the questions about your child below by choosing YES or NO.
These questions help us to assess the health, development, and safety of your child.

General Health		
Do you have concerns about your child's health?	NO	YES
Any problems with previous immunizations?	NO	YES
Do you have an concerns about managing your child's behavior?	NO	YES
Feeding/ Nutrition		
Is your child breast feeding still?	YES	NO
How often?		
Is your child taking formula or milk well?	YES	NO
How many ounces?		
Which formula or milk?		
Is your child getting three meals of solid foods per day?	YES	NO
Is your child feeding him or herself?	YES	NO
Can your child drink from a sippy cup?	YES	NO
Is your child weaning from the bottle?	YES	NO
Does your child drink juice or other sweetened drinks?	NO	YES
Is your child taking any vitamins or supplements?	YES	NO
Oral Health		
Are cavities a problem for you or anyone in your family?	NO	YES
Does your child sleep with a bottle?	NO	YES
Does your child breast or bottle-feed during the night?	NO	YES
Are you using a soft toothbrush or cloth to clean child's teeth two times a day?	YES	NO
Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Do you have a dentist for your child?	YES	NO
Elimination		
Are they having problems with bowel movements (pooping)?	NO	YES
Activity/Exercise/Screen time		
Does your child watch TV?	NO	YES
Do you play and read to your child everyday?	YES	NO
Does your child get supervised floor time every day?	YES	NO
Sleep		
Does your child sleep through the night?	YES	NO
Do you have a bedtime routine?	YES	NO
Social Stressors		
Are you able to take a little time for yourself?	YES	NO
Any major changes or stresses in your family recently?	NO	YES
Do you ever worry your family will go hungry?	NO	YES
Do you have daycare concerns?	NO	YES

12 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: _____ DOB: _____

Development		
Does your child babble and imitate words and sounds?	YES	NO
Does your child say one or two words?	YES	NO
Does your child point to show wishes or interest?	YES	NO
Do they follow simple directions?	YES	NO
Do they hand you a book to read?	YES	NO
Do they wave bye-bye and play peek-a-boo?	YES	NO
Does your child bang toys together?	YES	NO
Do they cry when you leave?	YES	NO
Are they eating finger foods with thumb and forefinger (pincer)?	YES	NO
Are they walking with minimal or no assistance?	YES	NO
Are they creeping up the stairs?	YES	NO
Lead		
Are you living in a house built prior to 1978?	NO	YES
Is there any peeling or chipping paint?	NO	YES
Is there any recent, ongoing, or planning of remodeling?	NO	YES
Has a sibling or playmate ever had lead poisoning?	NO	YES
Safety		
Do you always stay close enough to touch your child when he/she is in the bath?	YES	NO
Does your child wear any jewelry including necklaces?	NO	YES
Do you hold or carry hot liquids around the baby?	NO	YES
Do you have a gate on your stairs?	YES	NO
Is your child's crib mattress at the lowest position?	YES	NO
Do you have a swimming pool, pond, or lake near your home?	NO	YES
Do you keep plastic bags and latex balloons away from your baby?	YES	NO
Does your baby ride in a rear facing safety seat, in the back seat?	YES	NO
Is your baby exposed to anyone who smokes?	NO	YES
Have you turned the water heater to below 120 degrees?	YES	NO
Have you constructed barriers around space heaters, wood stoves, etc.?	YES	NO
Are there working smoke detectors and carbon monoxide detectors in the home?	YES	NO
Have you locked up your household cleaners, chemicals, and medicines?	YES	NO
Do you keep furniture away from windows or use window guards?	YES	NO
Is there a gun in the home?	NO	YES
Is it locked or in a safe?	YES	NO
Do you have the number for Poison Control?	YES	NO
Are you using sunscreen or shading your baby, if they are in the sun more than 10 minutes?	YES	NO
Tuberculosis		
Has a family member or contact had tuberculosis disease?	NO	YES
Has a family member or contact had a positive TB skin test (PPD)?	NO	YES
Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
Has your baby traveled to a high-risk country for more than a week?	NO	YES
Review of Systems		
Do you have any concerns about your baby's hearing?	NO	YES
Do you have any concerns about your baby's vision?	NO	YES
Does your baby ever appear cross-eyed?	NO	YES