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 theses 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	2nd 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

Northwest PRIMARY CARE

15 MONTH
PEDIATRIC DEVELOPMENTAL SCREENING

Date: _____

Name: _____ DOB: _____ Male Female

Physician Signature: _____

Instructions: Please answer the questions below about your child 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
Feeding/ Nutrition		
Is your child still breast feeding?	○ YES	○ NO
How often?		
Is your child taking formula or milk well?	○ YES	○ NO
How many ounces?		
Which formula or milk?		
Does your child have fruits or vegetables at every meal?	○ YES	○ NO
Are you giving your child mostly whole grains?	○ YES	○ NO
Do you avoid giving your child choking foods (raw vegetables, nuts, hotdogs, popcorn)?	○ YES	○ NO
Does your child still drink from a bottle?	○ NO	○ YES
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		
Does your child have problems with bowel movements (pooping)?	○ NO	○ YES
Activity/Exercise/Screen time		
Does your child watch TV?	○ NO	○ YES
Do you play with your child every day?	○ YES	○ NO
Do you read to your child every day?	○ YES	○ NO
Sleep		
Does your child sleep through the night?	○ YES	○ NO
Do you have a bedtime routine?	○ YES	○ NO
Does your child fall asleep on their own in their own bed?	○ YES	○ NO

15 MONTH PEDIATRIC DEVELOPMENTAL SCREENING

Name: _____ DOB: _____

Social Stressors		
Are you able to take some 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
Does your partner ever hurt you or your children?	○ NO	○ YES
Do you have daycare concerns?	○ NO	○ YES
Behavior		
Does your child display excessive tantrums?	○ NO	○ YES
Do you have questions about discipline?	○ NO	○ YES
Do you praise your child when they are behaving well?	○ YES	○ NO
Development		
Does your child know one body part?	○ YES	○ NO
Does your child communicate wishes well?	○ YES	○ NO
Does your child bring objects to show you?	○ YES	○ NO
Does you child jabber a great deal?	○ YES	○ NO
Do they say four to five words clearly?	○ YES	○ NO
Do they understand and follow simple commands?	○ YES	○ NO
Are they walking well?	○ YES	○ NO
Do they enjoy scribbling?	○ YES	○ NO
Do they copy things you do?	○ YES	○ NO
Do they listen to stories?	○ YES	○ NO
Safety		
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 infant ride in a rear facing safety seat, in the back seat?	○ YES	○ NO
Is your infant exposed to anyone who smokes?	○ NO	○ YES
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
Is there a gun in the home?	○ NO	○ YES
If 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