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

2 1/2 YEAR
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 any concerns about your child's health?	○ NO	○ YES
Any problems with previous immunizations?	○ NO	○ YES
Feeding/ Nutrition		
Is your child drinking milk?	○ YES	○ NO
How many ounces per day?		
What type of milk?		
Does your child have fruits or vegetables at every meal?	○ YES	○ NO
Are you giving your child mostly whole grains?	○ YES	○ NO
Does your family eat junk foods (chips, cookies, crackers,candy) or fast foods daily?	○ NO	○ YES
Does your child drink juice or other sweetened drinks?	○ NO	○ YES
Is your child taking any vitamins or supplements?	○ YES	○ NO
Lipids		
Have any parents or grandparents experienced a stroke or heart attack before age 55?	○ NO	○ YES
Do either parent have high cholesterol or are on cholesterol medication?	○ NO	○ YES
Oral Health		
Are cavities a problem for you or anyone in your family?	○ 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 a daily soft bowel movement (poop)?	○ YES	○ NO
Do you have any questions about toilet training?	○ NO	○ YES
Activity/Exercise/Screen time		
Does your child watch TV or play video games more than 1 hour per day?	○ NO	○ YES
Is there a TV in your child's bedroom?	○ NO	○ YES
Do you read to your child every day?	○ YES	○ NO
Do you encourage family activities such as walking, bicycling, swimming, or dancing?	○ YES	○ NO
Do you do educational activities as a family, such as go to museums, zoos, or libraries?	○ YES	○ NO
Do you eat meals together as a family?	○ YES	○ NO
Sleep		
Does your child sleep through the night?	○ YES	○ NO
Do you have a bedtime routine?	○ YES	○ NO
Does you child fall asleep on their own in their own bed?	○ YES	○ NO
Does your child snore more than a little?	○ NO	○ YES

2 1/2 YEAR PEDIATRIC DEVELOPMENTAL SCREENING

Name: _____ DOB: _____

Social Stressors		
Are you able to take some time for yourself?	◯ YES	◯ NO
Have you had 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
Does your partner ever hurt you or your children?	◯ 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
Do you give you child choices?	◯ YES	◯ NO
Development		
Does your child put three to four words together in a sentence?	◯ YES	◯ NO
Do others understand your child's speech half the time?	◯ YES	◯ NO
Does you child know eight or more body parts?	◯ YES	◯ NO
Do they know the correct animal sounds?	◯ YES	◯ NO
Can they brush their teeth with help?	◯ YES	◯ NO
Can they carry out a two-step command?	◯ YES	◯ NO
Can they jump with both feet off the floor?	◯ YES	◯ NO
Safety		
Do you watch your child when they are playing outside?	◯ YES	◯ NO
Do you keep your child away from vehicles, lawn mowers, driveways, and streets?	◯ YES	◯ NO
Does you child wear a helmet when on a tricycle or bicycle?	◯ YES	◯ NO
Is your child exposed to anyone who smokes?	◯ NO	◯ YES
Is there a gun in the home?	◯ NO	◯ YES
Is it locked or in a safe place?		
Does your home have working smoke detectors and carbon monoxide detectors?	◯ YES	◯ NO
Does your child ride in a forward-facing safety seat, in the back seat?	◯ YES	◯ NO
Do you use sunscreen on your child for prolonged sun exposure?	◯ YES	◯ NO
Do you have the number for Poison Control?	◯ YES	◯ NO
Do you have a swimming pool, pond, or lake near your home?	◯ NO	◯ YES
Tuberculosis		
Has a family member or a contact had tuberculosis disease?	◯ NO	◯ YES
Has a family member had a positive TB skin test (PPD)?	◯ NO	◯ YES
Was your child born in a high-risk country (countries other that the U.S., Canada, Australia, or Western Europe?	◯ NO	◯ YES
Has your child traveled to a high-risk country for more than a week?	◯ NO	◯ YES
Review of Systems		
Do you have any concerns about your child's hearing?	◯ NO	◯ YES
Do you have any concerns about your child's vision?	◯ NO	◯ YES