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Contact: ip_officer@health.qld.gov.au

Queensland Government

Health Check 12 months

Medicare Item No. 228, 715, 10987

Facility: ______________________

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Patient's actual age:

Indigenous status: ☐ Aboriginal only ☐ Torres Strait Islander only ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Not stated/unknown

Parent / carer's name:	Relationship:	Signature (health check consent):	Date:

Have all the benefits, risks, outcomes and results of this health assessment been discussed and explained to the parent/carer by the clinician? ☐ Yes ◯ No

Legend: ◯ Indicates a health risk requiring brief intervention, follow up or action. For support see the Chronic Conditions Manual

DO NOT WRITE IN THIS BINDING MARGIN

Family History

Medical History

Current problems/ concerns

Allergies

Immunisation status

Has the infant had all age related eligible vaccines? ☐ Yes ◯ No

Vaccines due:

Initial	Date

HEALTH CHECK 12 MONTHS

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Family name:	Given name(s):	URN:

Body measurements

Weight	kg	(.................. %le)	☐ Healthy ◯ Underweight ◯ Overweight
Length	cm	(.................. %le)	☐ Healthy ◯ Other
Head circumference	cm	(.................. %le)	☐ Normal ◯ Other
Anterior fontanelle	☐ Normal ◯ Other		Initial Date

Clinical measurements

Breathing	☐ Normal	◯ Other	
Heart sounds	☐ Normal	◯ Other	Initial Date

General appearance

Head, neck and face		☐ Healthy	◯ Other ______		
Limbs and joints	Hips abduct equally:	☐ Yes	◯ No		
	Buttock creases equal:	☐ Yes	◯ No		
Genitalia	Appearance:	☐ Normal	◯ Other ______		
	Left teste:	☐ Descended	◯ Undescended	◯ Not found	☐ N/A Date
	Right teste:	☐ Descended	◯ Undescended	◯ Not found	☐ N/A Initial

Skin

Has the infant had any skin infections?	☐ No	◯ Yes	
Inspect skin. Any concerns? Describe	☐ Normal	◯ Other	Initial Date

Developmental milestones

Notices someone new	◯ No	☐ Yes
Plays early turn based games e.g. peekaboo	◯ No	☐ Yes
Babbles phrases that sound like talking	◯ No	☐ Yes
Responds to familiar words e.g. puppy, mummy	◯ No	☐ Yes
Feeds self e.g. with finger foods or holding own cup	◯ No	☐ Yes
Able to pick up small items using index finger and thumb (pincer grip)	◯ No	☐ Yes
Moves independently e.g. creeping or crawling motion	◯ No	☐ Yes
Pulled to stand independently and holds on for support	◯ No	☐ Yes

If 'No' to any above, perform an ASQ or ASQ-TRAK and refer

Any parental concerns according to PEDS assessment? (See child's PHR booklet)	◯ Yes	☐ No
Difference in strength, movement and tone between right and left sides of body?	◯ Yes	☐ No
Significant loss of skills?	◯ Yes	☐ No
Poor interaction with adults or other children?	◯ Yes	☐ No
Lack of response to sound or visual stimuli?	◯ Yes	☐ No
Loose and floppy movements (low tone) or stiff and tense (high tone)?	◯ Yes	☐ No
Not achieving indicated developmental milestones?	◯ Yes	☐ No
Lack of or limited eye contact?	◯ Yes	☐ No

If 'Yes' to any above, perform an ASQ or ASQ-TRAK and refer Initial Date

Ears and hearing

Does the parent think their infant can hear them?	☐ Yes	◯ No
Does the infant turn towards sounds or voices?	☐ Yes	◯ No
Is the parent happy with their infant's hearing?	☐ Yes	◯ No
Has the infant been free of ear infections or discharge?	☐ Yes	◯ No

If 'No' to any above OR of Aboriginal and Torres Strait Islander descent OR from a rural and remote location perform otoscopy and tympanometry

Otoscopy (describe)	Right ear:	☐ Healthy	◯ Other ______	
	Left ear:	☐ Healthy	◯ Other ______	
Tympanometry	Right ear:	☐ Type A	◯ Type B	◯ Type C
	Left ear:	☐ Type A	◯ Type B	◯ Type C

Initial Date

Physical activity

Does the infant do floor based play daily e.g. tummy time, rolling, crawling, cruising?	☐ Yes	◯ No	
Is the infant physically active for > 3 hrs/day?	☐ Yes	◯ No	Initial Date

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Date of birth: Sex: ☐ M ☐ F

Section	Item				
Eyes vision	Red eye reflex	☐ Present	○ Absent		
	Fixates and follows an object	☐ Present	○ Absent		
	Corneal light reflex equal	☐ Present	○ Absent	Initial	Date
Nutrition	Breast or formula feeding?	☐ Yes	○ No		
	Eating solids?	☐ Yes	○ No		
	Uses a cup or bottle?	☐ Yes	○ No		
	Healthy foods and drinks?	☐ Yes	○ No		
	Nutritionally poor foods and drinks?	☐ No	○ Yes		
	Does the infant always have access to food?	☐ Yes	○ No	Initial	Date
Oral health	Does the infant have any teeth?	☐ Yes	○ No		
	Examination of gums and teeth adequate?	☐ Yes	○ No		
	Does the parent clean the infant's teeth?	☐ Yes	○ No	Initial	Date
Social-emotional wellbeing	**Does the parent/carer have concerns about:**				
	» Coping?	☐ No	○ Yes		
	» Relationships (with family or friends)?	☐ No	○ Yes		
	» Support?	☐ No	○ Yes		
	» Violence?	☐ No	○ Yes		
	» Child's behaviour?	☐ No	○ Yes		
	Observe: Is interaction between parent and baby positive?	☐ Yes	○ No		
	If any concerns raised above, perform SDQ	Score: ______		Initial	Date
Environment	Where does the baby sleep?	☐ Cot	○ Other		
	Is the baby placed on their back to sleep?	☐ Yes	○ No		
	Is the baby exposed to cigarette smoke?	☐ No	○ Yes		
	How many people live in the house?	______			
	Any observed safety concerns?	☐ No	○ Yes	Initial	Date

Anticipatory guidance

- » Talking and reading to your infant
- » Being close to your infant, cuddling, smiling, eye contact and listening (bonding)
- » Injury prevention and reducing home hazards (e.g. car capsules, water)
- » Sun protection
- » Strategies for settling
- » Age appropriate healthy eating, fussy eating and strategies
- » Avoiding screen time
- » Support groups
- » Partner support and coping with infant
- » Contraception
- » Breast care, breastfeeding (attachment)
- » Normal developmental milestones
- » Handwashing
- » Sudden infant death syndrome

Initial Date

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Family name:	Given name(s):	URN:

Note any required actions and transfer to Care Management Plan

Medicare

Medicare item being claimed?	☐ Yes	○ No
All benefits, risks, outcomes and results of this health assessment discussed and explained to carer/parent by clinician?	☐ Yes	○ No (can not claim Medicare)
Written or photocopied feedback of action plan provided to parent?	☐ Yes	○ No (can not claim Medicare)
Medicare claim form signed by parent?	☐ Yes	○ No (can not claim Medicare)

Doctor name	Signature	Date

Signature log

Signature	Name	Date	Initial

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