Well Child Check: 12 Month Visit

Your Child’s Name: __________________________________________________

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Can your child get himself to a standing position? | Yes | No | Unsure
---|---|---|---
Does your child take steps holding on to furniture? | Yes | No | Unsure
Does your child walk? | Yes | No | Unsure
Does your child pick up objects with the tips of the thumb and fingers? | Yes | No | Unsure
Does your child feed herself? | Yes | No | Unsure
Can you get your child to laugh? | Yes | No | Unsure
Does your child babble? (talk with made up words/sounds) | Yes | No | Unsure
Does your child say dada or mama, with specific meaning? | Yes | No | Unsure
Does your child use any gestures? (wave bye-bye, point) | Yes | No | Unsure
Does your child look at you when you call his or her name? | Yes | No | Unsure
Is your child completely weaned from the bottle? | Yes | No | Unsure
Does your child usually drink more than 4 oz. of juice or sweetened drinks daily? | No | Yes | Unsure
Is your baby getting breast milk or formula? | Breast milk | Formula | Other
How much breast milk, formula or other milk does your child drink in 24 hours?________________________ oz.
Does your child eat meat (such as fish, chicken, beef, or pork)? | Yes | No | Unsure
Was your child born after the 37th week of pregnancy? | Yes | No | Unsure
Did your child weigh more than 5 pounds 8 ounces (2500 gm) at birth? | Yes | No | Unsure
Does your child sleep through the night? | Yes | No | Unsure
Do you usually protect your child with sunscreen/hats/other measures when outdoors? | Yes | No | Unsure
Do you have the poison control number (800 222-1222) posted at home? | Yes | No | Unsure
Are there guns at your home, or any home your child regularly visits? | No | Yes | Unsure
Does your child have access to a pool that does not have a locked gate? | No | Yes | Unsure
Do you have any safety concerns in your home? | No | Yes | Unsure
If so, what are your concerns?
________________________________________________________________________________________

Over the past 2 weeks, has mom ever felt down, depressed or hopeless? | No | Yes | Unsure
Over the past 2 weeks, has mom felt very little or no interest or pleasure in doing things? | No | Yes | Unsure
Who provides daytime care for your child? ________________________________

Does your water contain fluoride? | Yes | No | Unsure

Page 1 of 2
CONTINUES ON OTHER SIDE
Well Child Check: 12 Month Visit

Is your child on any medications or supplements, including vitamins? If so, please list below:

_________________________________________________________________________________________

RISK ASSESSMENT FOR LEAD EXPOSURE:

Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds?  
Yes  No  Unsure

Does your child live in or regularly visit a house or child care facility built before 1978 with peeling or chipping paint inside or outside the home?  
Yes  No  Unsure

Does your child have a sibling or playmate who has or did have lead poisoning?  
Yes  No  Unsure

Does your family use any of the following IMPORTED items: pottery for cooking or storing food, home remedies, dietary/herbal supplements, candy or eyeliner, (Kohl, Greta, Azarcon, Pay-loo-ah or others)? IF YES, please specify.  
_______________________________________________________________________________________

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?  
Yes  No  Unsure

Since your child’s last well check has a family member or contact had a positive tuberculosis test?  
Yes  No  Unsure

Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?  
Yes  No  Unsure

Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?  
Yes  No  Unsure

Do you have any international travel plans prior to your child’s second birthday, if so, when and where?  
_______________________________________________________________________________________

Do you have any concerns about your child’s development, or any other concerns you would like to discuss with your provider?  
If so, please describe:

_________________________________________________________________________________________
_________________________________________________________________________________________