12 - Month Well Check Questionnaire

Name _____

DOB _____

Chief Complaint Please circle or print appropriate answer

Do you have any concerns about your child?

Yes No

If so, explain _____

Does your child have any special health care needs?

Yes No

If so, explain _____

Has your child seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

If so, explain _____

Has your child had any procedures or tests done since your last visit?

Yes No

If so, explain _____

Besides this child, how many people are living in this child's home?

_____

Including: Mother Father Sibling(s) Maternal Grandparent(s)

Paternal Grandparent(s) Significant other of Mother Friend(s)

Significant other of Father Other Family Member(s)

If this child is not living with both biological parents, what is the living situation?

Joint custody Single custody Family Member Foster home

Adoptive home Other

If other, explain _____

Who takes care of your child during the day?

Parent Family member Babysitter/Nanny Daycare

Other

Have there been any major changes for your child or in your family lately?

Yes No

What kind of change?

Separation Divorce Change in caregiver Move

Return to work/school Job change Loss of job Money Problems

Significant illness Death in the family Other

Does your child live with anyone who smokes or spend time in any places where people smoke? Does anyone smoke in the care your child travels in?

Yes No

Has your child ever been diagnosed with iron deficiency anemia?

Yes No

Do you ever have trouble getting food on the table?

Yes No

Do you know about community resources like WIC, Head start and food stamps?

Yes No

Is your child on a strict vegetarian diet?

Yes No

If your child eats a vegetarian diet, does your child's diet include iron?

Yes No

Does your child's diet include iron rich foods like meat eggs beans or iron fortified cereals?

Yes No

Does your child have a sibling or playmate who has or had lead poisoning?

Yes No

Does your child spend time in a house or child care facility that was built before 1978 that is under renovations or remodeling or had been within the last 6 months?

Yes No

Does your child spend time in a house or child care facility that was built before 1950?

Yes No

Does your child eat or drink our of pottery or ceramic dishes? Do you cook with pottery or ceramic pots or pans?

Yes No

If your child was adopted, was the adoption from another country?

Yes No

Has your child recently immigrated from another country?

Yes No

Does this child have any caregivers that do any smelting, soldering, or auto body repair?

Yes No

Do you give your child any home or folk remedies?

Yes No

Has your child been exposed to someone with tuberculosis?

Yes No

Has a family member or contact had a positive tuberculin skin test?

Yes No

Was your child born in a country with a high risk of tuberculosis (countries other than of the US, Canada, Australia, New Zealand or Western Europe)?

Yes No

Has your child traveled (and had contact with resident populations) for more than 1 week to a country at high risk for tuberculosis?

Yes No

Is your child infected with HIV?

Yes No

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Review of Systems Please circle or print appropriate answer

If your child drinks formula or milk, how many ounces do they drink per day? _____

What kind of milk or formula does your child drink?

Similac Enfamil Good Start Generic Brand Cow

Soy Rice Almond Other milk source

How many feedings does your child have per day?_____

How many ounces of water does your child drink per day? _____

Where does your child's drinking water come from?

Tap Well Bottled

How many ounces of juice does your child drink per day? _____

Does your child use a bottle or a cup?

Bottle Cup Both

Is your child eating solid foods like baby cereals and baby foods?

Yes No

What types of solid foods is your child eating?

Fruits Vegetables Grains Dairy Protein Junk Food

Fast Food

Is your child eating solid foods with different textures? For example, pureed, mashed, chopped and lumpy?

Yes No

Is your child feeding him/herself?

Yes More than 50% of the time Less than 50% of the time No

Do you let your child decide how much to eat?

Yes No

Does your child have any problems with eating?

Yes No

If so, describe _____

Do you have concerns that your child is frequently vomiting, throwing up or spitting up?

Yes No

How many times a day does your child vomit, throw up, or spit up? _____

Does your child take vitamins or supplements?

Yes No

If so, describe _____

Do you have concerns regarding your child's urination or peeing?

Yes No

If so, describe _____

Do you have concerns regarding your child's bowel movements or poop?

Yes No

If so, describe _____

How many hours does your child sleep at night? _____

How many naps does your child take per day? _____

How long does your child nap for? _____

Does your child have a regular bedtime routine?

Yes No

Is your child falling asleep on their own?

Yes No

Does your child have problems with sleeping?

Yes No

If so, describe _____

How often are your child's teeth (if any) and gums brushed?

Once per day Twice per day Does not brush

How often are your child's teeth flossed?

Once per day Twice per day Does not floss

Is your child drinking water that is fluoridated?

Yes No

Is your child taking a fluoride supplement?

Yes No

Has your child had fluoride varnish applied to their teeth in the last 6 months?

Yes No Not previously recommended

Has your child seen a dentist for a checkup?

Yes No

If so, who is your child's dentist? _____

Does your child sleep with a bottle or have the bottle propped up?

Yes No

If so, what is in the bottle?

Milk Water Juice

Does your child snack frequently?

Yes No

Has anyone in your child's family ever had a lot of cavities?

Yes No

Have you the parent or primary caregiver, had any cavities in the last 12 months?

Yes NO

Have you, the parent or primary caregiver, see a dentist on a regular basis?

Is your child eligible for Medicaid?

Yes No

Do you have concerns about the way your child hears?

Yes No

If so, describe _____

Do you have concerns about the way your child speaks?

Yes No

If so, describe _____

Do you have concerns about the way your child sees?

Yes No

If so, describe _____

Does your child hold objects close to focus?

Yes No

Do you have concerns about the way your child's eyes look?

Yes No

If so, describe _____

Has your child ever had an injury to their eye?

Yes No

If so, describe _____

How many hours a day does your child spend being physically active? _____

Does your child spend some time playing on their tummy?

Yes No

Is your family physically active together?

Yes No

How many hours a day does your child spend watching TV or other electronic device screens? For example, computer, tablet, game console?

More than 2 hours Les than 2 hours None

Do you or anyone else have concerns about your child's behavior?

Yes No

If so, describe _____

How do you respond to your child's good behavior? _____

How do you respond to your child's bad behavior? _____

Do all caregivers agree on ow to raise this child?

Yes No

Do you discuss your child's behavior and discipline with other caregivers?

Yes No

When your child rides in a car, do you use a car seat?

Yes No

Where, in the car, is the care seat located?

Back seat Front seat

Which way is the car seat facing?

Forward Rear

Are there working smoke detectors in the house?

Yes No

Are there working carbon monoxide detectors in the house?

Yes No

Has your home and places your child spends time been baby-proofed? (Including staircases, cleaning products, electrical cords, heater, furniture)

Yes No

Do you have a list of emergency numbers that are easy to find?

Yes No

Are household cleaners, chemicals and medicines locked up?

Yes No

Is the phone number for Poison Control easily located?

Yes No

Is your child left alone on high places like changing tables or countertops?

Yes No

Does your child use an infant walker?

Yes No

Do you keep furniture away from windows?

Yes No

Are there window guards on window that are on the 2nd floor or higher?

Yes No

Is your child able to climb out of their crib?

Yes No

Is the crib placed on the lowest setting?

Yes No

Are your stairs gated at the top and bottom?

Yes No

Does your child play with small objects, latex balloons or plastic bags?

Yes No

Are the cords to window blinds out of your child's reach?

Yes No

Is your child left alone in the tub?

Yes No

Do you stay within arm's reach of your child when near water like bath tub and swimming pools?

Yes No

Is there a swimming pool, pond, or lake near your home or where your child spends time?

Yes No

Does the swimming pool, pond or lake have a gate or fence around it?

Yes No

Is the temperature of your hot water at or below 120F in the places your child frequents? (For example, at home, at babysitter's or daycare)

Yes No Unsure

Do your drink or carry hot liquids while holding your child?

Yes No

Are there barriers around space heater, woodstoves or kerosene heaters?

Yes No

Are there any guns in your home or where your child spends time?

Yes No

If so, are the guns unloaded and locked away?

Yes No