Well Baby Check: 12 month visit questionnaire

Interval History:
Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office? No Yes
Has your child had any reactions to vaccinations in the past? No Yes

Development:
Can your child hold a cup to drink? Yes No
Can your baby feed him/herself finger foods? Yes No
Can he or she pick objects up with the tip of thumb and index finger? Yes No
Does your child combine syllables (e.g. “dada,” “mama”)? Yes No
Does your child use gestures (point with finger/hand)? Yes No
Does your child understand words (“no,” “more”)? Yes No
Does he/she look at something when you point and say “look”? Yes No
Does your child play peek-a-boo, wave bye-bye, clap hands? Yes No
Does your child cruise along the furniture (walk holding on)? Yes No
Can your child stand without holding on to something? Yes No
Can your child walk alone? Yes No
Do you have any concerns about how your child sees? No Yes
Does your child hold objects close when trying to focus? No Yes
Do your child’s eyes appear unusual or seem to cross, drift or be lazy? No Yes
Do your child’s eyelids droop or does one eyelid tend to close? No Yes
Do you have concerns about how your child hears? No Yes
Do you have concerns about how your child speaks? No Yes

Dental Health:
Does your child’s primary water source contain fluoride? Yes No Unsure
If no, does your child take a fluoride supplement? Yes No N/A
Do you know a dentist to whom you can bring your child? Yes No

Staying Healthy/Safety:
Does your baby watch TV? No Yes
Does your home have a working smoke detector? Yes No
Have you turned down your water temperature to less than 120 degrees? Yes No N/A
If your home has more than one floor, do you have safety guards on the windows, and gates for the stairs? Yes No N/A
Do your home have cleaning supplies/medicines/matches locked away? Yes No
Does your home have the number of the Poison Control Center 
(800-222-1222) posted by your phone?  
Yes No

Do you always stay with your baby when she/he is in the bathtub?  
Yes No

Do you and your baby spend time near water (pool, river or lake)?  
If so, is your baby always safely supervised?  
Yes No N/A

Do you use sunscreen when your child is outdoors?  
Yes No

Do you always place your baby in a rear-facing car seat in the back seat?  
Yes No

Is your car seat the right one for the age and size of your baby?  
Yes No

Does your baby spend time with anyone who smokes?  
No Yes

Does your baby spend time in a home where a gun is kept?  
If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?  
Yes No N/A

Risk Assessment for Lead Exposure:

Does your child participate in any publicly supported programs 
(MediCal, CHDP, Healthy Families, or WIC)?  
No Yes

Does your child live in or regularly visit a house or child care facility 
built before 1950?  
No Yes

Does your child live in or regularly visit a house or child care facility 
built before 1978 that is being or has recently been renovated or 
remodeled (within the last 6 months)?  
No Yes

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

Does your child take any imported remedies or supplements?  
No Yes

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate?  
No Yes

This includes all countries other than the United States, Canada, 
Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate 
for one month or more? (Countries other than those listed above)  
No Yes

Has your child had contact with someone (including family member, childcare 
provider, or other caretaker) with known TB infection, or who has been 
treated for TB infection?  
No Yes Unsure

Is your child immunosuppressed (currently or planned)?  
This includes HIV infection, organ transplant recipient, other immune 
system problems, or treatment with immunosuppressive medications.  
No Yes

Sleep:

How many hours does your baby sleep at night?  
______ hours

How many hours does your baby nap throughout the day?  
______ hours

Does your baby sleep through the night without feeding?  
Yes No
Nutrition:

How much milk does your child drink? _____ oz per day. Type: [breast milk] [formula] [whole milk] [other _____]

How much juice does your child drink in 24 hours? _____ oz per day

Is your child eating fruits and vegetables well? Yes No

Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, milk, soy milk, cheese, yogurt, or tofu? Yes No

Does your child eat meat (such as chicken, fish, beef or pork)? Yes No

Do you offer your child a sippy cup every day? Yes No

Do you give your baby a bottle of anything except formula, milk or water? No Yes

Do you have any concerns about your baby’s feeding? No Yes

Elimination:

Does your baby have bowel movements on a regular basis with a normal (soft) consistency? Yes No

Please list any medications or supplements your baby is taking, including vitamin D:

__________________________________________________________________________________________________________________________________________

Who lives in the home with your baby? ____________________________________________

Who provides daytime care for your child? __________________________________________

Please list any major family medical issues: _________________________________________

Please list any known allergies to medicines: ________________________________________

Please list any known food allergies: ______________________________________________

Do you have any concerns about your child’s development, or any other concern you would like to discuss with your provider? ____________________________________________

Parent or Guardian Signature: ____________________________________________

Date: ____________________________

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PCP’s Signature: ____________________________

Print Name: ____________________________

Date: ____________________________