Patient Name

Date of Birth

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 ☐

Does 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)? No ☐ Yes ☐
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? No ☐ Yes ☐ Skip ☐
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)? No ☐ Yes ☐
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

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: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date: