Medical Record Number

Patient Name

Patient Label

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	

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Question			
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:

Question		
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:

Question			
Was your child born in a country with an elevated TB rate? This includes all countries ***other than*** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.	No	Yes	
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:

Question		
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

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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: