12 Month Pre-Visit Questionnaire

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions.

CHILD'S NAME:______________________________ DATE OF BIRTH:_______________________

YOUR NAME:________________________________RELATIONSHIP:________________________

Do you have any concerns, questions or problems that you would like to discuss today? Please describe:____
____
____

Does your child have any allergies? YES/NO If yes, please list:_____________________________
Does your child take any medications? YES/NO If yes, please list_________________________
Has your child seen any other healthcare providers? YES/NO If yes, please list:_______________

FEEDING/NUTRITION

Is your child drinking whole milk? YES/NO If no, what do they drink?______________________
What types of food is your child eating?____
____

Have there been any recent changes in your family? (check all that apply)

_____ Death _____ Divorce Other: __________________________
_____ Job Change _____ Move __________________________

CHILDCARE:

Does your child attend daycare? YES/NO If yes, where?___________________________________

Review of Systems	Yes	No
Do you have concerns about how your child hears?		
Do you have concerns about how your child sees?		
Do you have concerns about your child's development or behavior?		
Does your child have a hard time sleeping?		
Does your child have a hard time calming down?		

Risk Assessment	Never	Sometimes	All the time
Does your child live with anyone who uses tobacco or spend time in a place where people smoke?			
Has a family member's drinking or drug use ever had a bad effect on your child?			
In the past year did you ever worry that your food would run out before you got money to buy more?			

	Yes	No
Does your child live in or visit a house build before 1950?		
Does your child live in or visit a house built before 1978 that has been renovated in the past 6 months?		
Does your child have a sibling or playmate who has had lead poisoning?		
Does your child have a family member who participates in a lead related job or hobby (casting or soldering – bullets, fishing weights, stained glass)?		
Does your child have a family member who uses traditional folk medicines or cosmetics or routinely imports food from abroad?		
Does your child live near lead smelters, battery recycling plants or other industries that might release atmospheric lead?		

	Yes	No
Has a family member or contact had tb or had a + skin test?		
Was your child born in a country at high risk for tb (any country other than the US, Canada, Australia, New Zealand or Western Europe)?		
Has your child traveled to a country other than the US, Canada, Australia, New Zealand or Western Europe and stayed longer than a week?		

	Yes	No
Are cavities a problem for you or for anyone in your family?		
Does your child sleep with a bottle or nurse frequently at night?		

DEVELOPMENTAL MILESTONES: Please put a check beside the things your child is able to do

____ Tries to copy sounds
____ Looks at things you are looking at
____ Stands alone
____ Drinks from a sippy cup
____ Says "mama" or "dada"
____ Waves bye-bye
____ Cries when you leave
____ Takes some steps alone
____ Says a few words
____ Plays peek-a-boo