

12 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's...

- 1. Feedings?..... Yes No
 Breast Whole Milk Solids
2. Excessive spitting or vomiting? Yes No
3. Bowel movements Yes No
4. Congestion or wheezing? Yes No
5. Skin color or rashes (circle one)? Yes No
6. Overall development? Yes No
7. Sleep habits? Yes No

Answer the following:

- 8. Is your child exposed to tobacco smoke? Yes No
9. Were there any problems with immunizations in the past? Yes No
11. Have you been sad, depressed or crying excessively? Yes No
11. Has your child traveled out of the country or do you plan to take your child to a
country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the
next year? Yes No
12. Is your water source from a well? Yes No

Does your child...

- 13. Say 1-3 words?..... Yes No
14. Understand his/her name and the word "No"? Yes No
15. Become shy or anxious with strangers? Yes No
16. Finger feed him/herself using the thumb and forefinger?..... Yes No
17. Pull to a stand? Yes No
18. Crawl well? Yes No
19. Stand alone? Yes No
20. Walk with minimal or no assistance?..... Yes No
21. Move all extremities equally well?..... Yes No

Answer the following:

- 22. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
23. Does your child ride in a rear-facing infant safety seat? Yes No
24. Do you know infant CPR? Yes No
25. Have you put up gates to keep your baby in a safe, enclosed area? Yes No
26. Is your child eating all food groups: fruits, meats, and vegetables? Yes No
27. How many ounces of milk does your child drink in one day? _____ What kind? _____
28. Is your child drinking less than 6 ounces of juice per day? Yes No
29. Do you brush your child's teeth?..... Yes No
30. Have you started giving your child a multivitamin with iron? Yes No

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Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

- 1. Are you giving a multivitamin with iron? Yes No
- 2. Breast feeding mothers, are you taking a multivitamin with iron? Yes No
- 3. Do you need help from our lactation specialists? Yes No
- 4. Do you need help with preparations to return to work?..... Yes No

Screening questions for Tuberculosis:

- 1. Do you have a family member with TB or any contact with someone who has TB?..... Yes No
- 2. Do any family members have a positive TB test? Yes No
- 3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? Yes No
- 4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? Yes No
- 5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese?..... Yes No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

- 1. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months Yes No
- 2. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant Yes No

Lead Screening:

Does your child...

- 1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) Yes No
- 2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? Yes No
- 3. Have a sibling or playmate who now has or did have lead poisoning? Yes No
- 4. Is your child a refugee from another country? Yes No
- 5. Does your child have their health insurance provided by Medicaid or INtotal Health? . Yes No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? Yes No
