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

_____

_____

_____

_____

_____