12 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have concerns about your child's health?	NO	YES
2	Do you have any concerns about managing your child's behavior?	NO	YES
3	Has your child had any problems with shots or immunizations?	NO	YES
4	Does your child receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

5	Do you have any concerns about your child's hearing?	NO	YES
6	Do you have any concerns about your child's vision?	NO	YES
7	Does your child ever look cross-eyed?	NO	YES

Feeding/Nutrition

8	Is your child breastfeeding?	YES	NO
	a. How often?		
9	Is your child taking formula or milk well?	YES	NO
	a. Which kind of milk or formula?		
	b. How many ounces of milk per day?		
10	Is your child eating three meals of solid food per day?	YES	NO
11	Is your child feeding him or herself?	YES	NO
12	Can your child drink from a sippy cup?	YES	NO
13	Are you weaning from the bottle?	YES	NO
14	Does your child drink juice or other sweetened drinks?	NO	YES
15	Do you give your child any vitamins or supplements?	YES	NO

Oral Health

16	Has your child started to see a dentist? (**If your answer is yes, please skip ahead to #21**)	YES	NO	
	ANSWER #17-20 *ONLY* IF YOUR CHILD HAS *NOT* SEEN A DENTIST			
17	Has any caregiver had cavities/dental decay in the past year?	NO	YES	
18	Does your child drink something other than water from a cup continually and/or snack frequently throughout the day?	NO	YES	
19	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO	NOT SURE
20	Do your brush your child's teeth with a fluoride-containing toothpaste (size of a grain of rice) twice daily?	YES	NO	

Elimination

21	Does your child have any problems with bowel movements (pooping)?	NO	YES

Activity / Exercise / Screen Time

22	Does your child have screen time (smartphone, tablet, TV)?	NO	YES
23	Do you play with and read to your child every day?	YES	NO
24	Does your child get supervised floor time every day?	YES	NO

Sleep

25	Does your child sleep through the night?	YES	NO
26	Do you have a bedtime routine?	YES	NO

Social Stressors

27	Have there been any major changes or stresses in your family recently?	NO	YES	
28	Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
29	Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

Development

30 Does your child babble, copy words you say, and make sounds?	YES	NO
31 Does your child say one or two words?	YES	NO
32 Can your child follow simple directions?	YES	NO
33 Does your child give you a book to read?	YES	NO
34 Does your child wave bye-bye and play peek-a-boo?	YES	NO
35 Does your child bang toys together?	YES	NO
36 Does your child eat finger foods with thumb and forefinger (pincer)?	YES	NO
37 Does your child walk well or with a little help? (like holding onto your fingers)?	YES	NO
38 Can your child creep up stairs?	YES	NO

Lead

39 Is your child regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
40 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

41 Do you always stay close enough to touch your child when he or she is in the bath?	YES	NO	
42 Do you keep furniture away from windows or use window guards?	YES	NO	
43 Does your child wear any jewelry (including necklaces)?	NO	YES	
44 Do you have a gate on your stairs?	YES	NO	DOESN'T APPLY
45 Is the crib mattress at the lowest position?	YES	NO	
46 Do you hold or carry hot liquids around your child?	NO	YES	
47 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO	
48 Does anyone smoke or vape around your child?	NO	YES	
49 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
50 If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15-30 minutes?	YES	NO	DOESN'T APPLY
51 Do you keep plastic bags and latex balloons away from your child?	YES	NO	

52 Is your water heater turned to below 120 degrees?	YES	NO	
53 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO	
54 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
55 Do you have the number for Poison Control?	YES	NO	
56 Is there a swimming pool, pond or lake near your home?	YES	NO	
a. If yes, it is secured so that your child cannot access it?	YES	NO	DOESN'T APPLY
57 Is there a gun in the home?	NO	YES	
a. If yes, is it locked in a safe with the ammunition stored separately?	YES	NO	DOESN'T APPLY

Tuberculosis

58 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
59 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
60 Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
61 Has your child traveled to a high-risk country for more than a month?	NO	YES