Stanford Children's Health

Patient Name/Date of Birth: _____

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	

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:

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:

Has a family member or contact had tuberculosis or a positive tuberculin skin test (PPD)?	No	Yes	Unsure
Was your child born in a high risk country (countries ***other than*** the US, Canada, Australia, New Zealand or Western Europe)?	No	Yes	
Has your child traveled to (***or*** had contact with people who live in a high risk country) for more than one week? (Countries ***other than*** the US, Canada, Australia, New Zealand or Western Europe)	No	Yes	

Sleep:

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?

_____

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:

Ver.5-1-15