12 month – well child care **Patient Name:_____D.O.B_____**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household

Who lives in the home (e.g. Father, mother, brother, sister, etc.)? _____

Does your child attend daycare?_____ ▢ Yes ▢No

Development

Waves "bye-bye"_____ ▢ Yes ▢No
Calls a parent "mama" or "dada" or another special name _____ ▢ Yes ▢No
Understands "no" (pauses briefly or stops when you say it)_____ ▢ Yes ▢No
Puts something in a container, like a block in a cup_____ ▢ Yes ▢No
Looks for things they see you hide, like a toy under a blanket_____ ▢ Yes ▢No
Pulls up to a stand_____ ▢ Yes ▢No
Walks, holding on to furniture_____ ▢ Yes ▢No
Drinks from a cup without a lid, as you hold it_____ ▢ Yes ▢No
Picks things up between thumb and pointer finger, like bits of food____ ▢ Yes ▢No
Plays a game with you, like pat-a-cake_____ ▢ Yes ▢No

Nutrition

What types food are being given? ▢Whole Milk ▢Breast Fed ▢Formula _____
_____
_____

Avoiding excessive added sugars like candy and juice, as well as excess animal fats like bacon and cheese?_____ ▢ Yes ▢No
Consuming green vegetables?_____ ▢ Yes ▢No

Weaned from bottle? _____ ▢ Yes ▢No

Bowel habits

How many stools does you child have per day? _____

What do the stools look like (soft, seedy, loose)? _____

Sleep Pattern

Sleeps throughout the night in their own crib?_____ ▢ Yes ▢No

Safety

Is your child's car seat rear facing and in the back seat?_____ ▢ Yes ▢No
Is your child exposed to tobacco smoke?_____ ▢ Yes ▢No
Are there any improperly stored firearms in the home?_____ ▢ Yes ▢No
Is the home childproofed?_____ ▢ Yes ▢No
Is the hot water temperature set low enough to prevent accidental burns?_____ ▢ Yes ▢No
Are there working smoke detectors in the home?_____ ▢ Yes ▢No

Please share any concerns that you have about your child here:

_____

_____

_____

Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Please complete both sides of this form