12 Month Visit

NAME DATE

Are you concerned about your child's……..

1.Feedings and nutrition?	YES	NO
2. Bowel movements?	YES	NO
3. Skin color or rashes?	YES	NO
4. Overall development?	YES	NO
5. Sleep habits?	YES	NO
6. Vision or hearing?	YES	NO

Does your child……

1. Play interactive games? (peek-a-boo, pat-a-cake)	YES	NO
2. Imitate activities?	YES	NO
3. Hand you a book when he/she wants to hear a story?	YES	NO
4. Wave "bye-bye"?	YES	NO
5. Show distress on separation?	YES	NO
6. Imitate vocalizations and sound?	YES	NO
7. Speak 1 to 2 words?	YES	NO
8. Jabber with inflections of normal speech?	YES	NO
9. Follow simple directions?	YES	NO
10 Identify persons on request? (Where is _____?)	YES	NO
11. Stand alone?	YES	NO
12. Walk?	YES	NO
13.Bang to objects together?	YES	NO

Do you….

1. Have smoke alarms in the house?	YES	NO
2. Keep your child in a rear facing car-seat in the back seat?	YES	NO
3. Have the hot water heater in your home turned down to 120 degrees?	YES	NO
4. Keep your child away from cigarette smoke?	YES	NO

Tuberculosis Screen (TB)

1. Has a family member or contact had tuberculosis disease?	YES	NO
2. Has a family member had a positive TB test?	YES	NO
3. Was your child born outside the US, Canada, Australia, New Zealand or Western Europe?	YES	NO
4. Has your child traveled to a high risk country for more than 1 week?	YES	NO

LEAD Screen (Pb)

1. Does your child live in or regularly visit a house built before 1950?	YES	NO
2. Does your child live in or visit a house built before 1978 with recent remodeling or renovation? (with in 6 months)	YES	NO
3. Have a sibling or playmate who now or did have lead poisoning?	YES	NO

over

Do you have any other concerns you wish to discuss? YES NO

Office use only

WT HT HC