



PATIENT NAME _____ AGE _____ SEX _____ EXAM. DATE _____

Welcome to you and your child. Please answer these questions and provide further information in the column to the right.

(Please explain right-hand column answers here.)

- | | | | |
|-----|--|-----|-----|
| 1. | Does your child seem to be growing and developing well? | Yes | No |
| 2. | Is your baby breast-feeding? (How often per day? _____) | Yes | No |
| 3. | Is your baby taking a bottle? (How often per day? _____) | No | Yes |
| | Ounces per day of Milk _____ Formula _____ Juice _____ | | |
| 4. | Is your baby taking solid foods and table foods well? | Yes | No |
| 5. | Does your baby sleep well at night? | Yes | No |
| 6. | Has your baby had any recent serious injuries or health problems? | No | Yes |
| 7. | Has s/he had any childhood diseases? <input type="checkbox"/> Roseola <input type="checkbox"/> Hand-Foot-Mouth | No | Yes |
| | <input type="checkbox"/> Strep <input type="checkbox"/> Other | | |
| 8. | Does your child have any allergies? _____ | No | Yes |
| 9. | Does your child take any medications or supplements regularly? | No | Yes |
| | <input type="checkbox"/> Vitamins <input type="checkbox"/> Fluoride Other: _____ | | |
| 10. | Do you clean your baby's teeth regularly? | Yes | No |
| 11. | Has the family had any major new stresses or illnesses recently? | No | Yes |
| 12. | Is your baby cared for by a babysitter or day care? | No | Yes |
| 13. | Do you always use a properly installed car seat for your baby? | Yes | No |
| 14. | Do you have a working smoke alarm? | Yes | No |
| 15. | Have you had formal CPR and First Aid training? | Yes | No |
| 16. | Do you have the poison control information phone number at home? | Yes | No |
| 17. | Is your baby regularly exposed to cigarette or tobacco smoke? | No | Yes |
| 18. | Does your family have any risk factors for tuberculosis? | No | Yes |
| | <input type="checkbox"/> TB, AIDS or HIV in family <input type="checkbox"/> Lived outside USA in last year | | |
| | <input type="checkbox"/> Exposure to homeless, prison, barracks or jail environments | | |
| 19. | Do you have any questions about the MMR, HIB, Hep. B, Pneumococcal or Chicken Pox vaccines? | No | Yes |
| 20. | Please review the Lead Exposure Questionnaire . Are any of those risk factors present for your child? | No | Yes |
| 21. | Does your 12 month old baby: | Yes | No |
| | <input type="checkbox"/> Cruise, walk with hand held | | |
| | <input type="checkbox"/> Play a simple ball game | | |
| | <input type="checkbox"/> Say Mama, Dada, or other sounds | | |
| | <input type="checkbox"/> Put toys in container | | |
| | <input type="checkbox"/> Turn toward his/her spoken name | | |
| | Does your 15 month old baby: | | |
| | <input type="checkbox"/> Walk well alone | | |
| | <input type="checkbox"/> Stack two blocks | | |
| | <input type="checkbox"/> Say 3 to 6 words | | |
| | <input type="checkbox"/> Understand simple commands | | |
| | <input type="checkbox"/> Use sounds to get your attention | | |
| 22. | Are there any special questions you would like to ask today? | No | Yes |
| | 1) | | |
| | 2) | | |
| | 3) | | |