12 Month Old Questions **Name, Date of birth _____**

Who is the child here with today? _____

GENERAL:

Illnesses, injuries, surgeries, hospitalizations since last visit? _____

Medications: _____

Medication allergies: _____

Food allergies: _____

Is your child taking vitamins? (Circle what applies) Fluoride, Multi-vitamin, None

SOCIAL:

Changes in child's environment? _____

Who lives with the child in your home? #____Mom, #____ Dad , #____ Brother, # ____ Sister, _____other

Water source: CITY, WELL, BOTTLED

Tobacco exposure: YES, NO

Pets?_____

Daycare: YES, NO

FEEDING:

What kind of milk does your child drink? _____

Does your child eat sold foods at least three times a day? _____

Does your child drink from a cup? YES, NO

Can your child feed him/herself finger foods? YES, NO

How many ounces of sweetened beverages (juice, tea, colas, sports drinks) does your child drink each day? _____

ELIMINATION: Any issues urinating or with bowel movements? _____

SLEEP: How many hours does your child sleep without waking through the night?_____

BEHAVIOR (circle one) No problems &usually happy, stranger anxiety, separation anxiety, clingy, frequently irritable

DEVELOPMENT:

1- Pulls to stand: YES, NO

2- Stands alone for 2-3 seconds: YES, NO

3- Walks supported: YES, NO

4- Walks alone: YES, NO

5- Picks up small objects with two fingers (pincer grasp): YES, NO

6- Bangs two objects together: YES, NO

7- Places objects in/out of container: YES, NO

8- Waves bye-bye: YES, NO

9- Understands some words (i.e., no/bye): YES, NO

10- Imitates speech: YES, NO

11- Points to desired objects: YES, NO

12- Plays social games (i.e., peek-a-boo): YES, NO

13- Imitates activities: YES, NO

14- Attempts to use objects correctly (cup, hairbrush, phone): YES, NO

15- Exhibits stranger shyness: YES, NO

16- Exhibits separation anxiety: YES, NO

17- Do you think that your child hears well? YES, NO

18- Do you think that your child sees well? YES, NO

19- Do you read to your child? YES, NO

TB Questions

Does your child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or abnormal chest x-ray?

YES, NO, UNKNOWN

Has your child been in close contact with a person sick with active TB? YES, NO, UNKNOWN

Has your child been exposed to anyone who has been in jail or prison in the past 5 years? YES, NO, UNKNOWN

Was your child born outside of the U.S. or has your child traveled outside the U.S.? YES, NO, UNKNOWN

Does your child have a household member who was born outside the U.S. or who has traveled outside the U.S.? YES, NO, UNKNOWN

Is your child been exposed to any of the following?

HIV infected individuals? YES, NO, UNKNOWN

Homeless persons YES, NO, UNKNOWN

Users of IV and/or other street drugs? YES, NO, UNKNOWN

Residents of nursing homes or group home? YES, NO, UNKNOWN

Migrant workers? YES, NO, UNKNOWN

Does your child have HIV, or risk factors for HIV or any other health problem that could lower the immune system? YES, NO, UNKNOWN

Has your child ever been in jail? YES, NO, UNKNOWN

{International Travel: Exposure to anyone who has traveled outside the United States in last 60 days: YES, NO,