



PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Questions for 12 Month Visit

Please complete the following questions as they apply to your child.

### NUTRITION

**What is your child drinking from?**

- a cup (sippy or open) only                       a bottle mostly and a cup (sippy or open) occasionally  
 a cup (sippy or open) mostly and a bottle occasionally                       a bottle only

**Are you breast feeding?**     yes     no

If yes, do you plan on weaning?     yes     no

**Is your child drinking milk?**     yes     no

If yes, what type?

- whole     1%     2%     skim     soy     rice     formula

**If yes, how much milk does your child drink per day?**

- < 8 oz     8 to 16 oz     16 to 24 oz     24 to 32 oz     > 32 oz

**How much juice, Gatorade, sports drinks, and soda pop does your child drink per day?**

- 0 to 4 oz     4 to 8 oz     8 to 16 oz     > 16 oz

**How much water does your child drink per day?**

- < 8 oz     8 to 16 oz     16 to 24 oz     > 24 oz

**Your child has what type of water source?**

- city     well     bottled with fluoride     bottled without fluoride

**What is your child eating?**

- all table foods                                       mostly table foods and some baby foods  
 mostly baby foods and some table foods     baby foods without any table foods

**How many scheduled meals is your child offered per day?**

- 1 to 2     2 to 3     3 to 4     > 4

**How many snacks is your child offered per day?**

- none     1     1 to 2     > 2

**Has your child eliminated any main food groups from his/her diet?**

- meats     vegetables     fruits     grains/breads

### ELIMINATION

**How frequent does your child have a bowel movement?**

- > every 4 days     every 3 to 4 days     every other day     everyday  
 1 to 2 times per day     > 2 times per day

**Is your child having any problems with his/her bowel movements?**     yes     no

If yes, please explain: \_\_\_\_\_

## SLEEP

Does your child have a transitional object for sleep?  yes  no

Does your child have a fairly consistent bedtime?  yes  no

Is your child using a pacifier to fall asleep?  yes  no

Where does your child fall asleep?

in his/her own room  in a room with a sibling  in his/her parents room  elsewhere

How many hours does your child sleep at night?

< 8  8 to 10  10 to 12  > 12

How many naps does your child take during the day?

none  1 to 2  > 2

Does your child have any problems with his/her sleep?

snoring  restless sleep  paused or startled breathing  difficulty falling asleep  night terrors  
 poor sleep quality (being tired after sleeping)  frequent nighttime awakenings  nightmares  teeth grinding  
 other: \_\_\_\_\_

## VISION

Do you have any concerns regarding your child's vision?  yes  no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

## HEARING

Do you have any concerns regarding your child's hearing?  yes  no

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

## DEVELOPMENT

Pulls to stand  yes  no

Walks holding onto furniture and may take a few steps alone  yes  no

Makes either "mama" or "dada" sounds or both  yes  no

Says at least one word  yes  no

Imitates sounds  yes  no

Plays social games such as pat-a-cake, peek-a-boo and so-big  yes  no

Waves "bye-bye"  yes  no

Points with index finger  yes  no

Locates sound by turning head  yes  no

Imitates familiar adult behavior, such as using a cup or a telephone  yes  no

Turns books face up but runs several pages at once  yes  no

Deliberately drops or throws toys  yes  no

Bangs, strikes and shakes toys  yes  no

Looks for and finds toys  yes  no

Eagerly explores objects and spaces  yes  no

Feeds self  yes  no

## SAFETY

What type of car seat does your child use?

- a 5 point (rear facing) infant carrier in the back seat of the vehicle  
 a 5 point (forward facing) infant carrier in the back seat of the vehicle  
 a 5 point (rear facing) toddler (convertible) seat in the back seat of the vehicle  
 a 5 point (forward facing) toddler (convertible) seat in the back seat of the vehicle  
 Other: \_\_\_\_\_

Do you have a pool?  yes  no

If yes, what type?

- above ground without a fence  in ground without a fence  above ground with a fence around the pool  
 above ground with a fence around the yard  in ground with a fence around the pool  in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



PATIENT NAME: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ ZIP CODE: \_\_\_\_\_

## Lead Screening

A documented result of a blood lead test or a properly filled out Childhood Lead Risk Assessment Questionnaire must be attached to a Certificate of Child Health Examination form for purposes of admission to an Illinois Department of Children and Family Services or state regulated child-care facility, including those operated by a school district.

**Respond to the following questions by checking the appropriate answer.**

- |  |                              |                             |                                  |
|--|------------------------------|-----------------------------|----------------------------------|
| Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does this child live in or regularly visit a home that was built before 1978?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Is this child a refugee or an adoptee from any foreign country?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

M.A.R. 5.2010      Signature of Provider \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Tuberculosis Screening

In order to determine whether or not a TB test is indicated for your child, we need you to answer the following questions. Because exposure risks can change, we will ask you to update this questionnaire at the 6, 12, 18, and 24 month well child visits and then annually until 21 years of age.

**Respond to the following questions by checking the appropriate answer.**

- |   |   |
|---|---|
| Has a member of your family or a person who has contact with your child and tuberculosis disease?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has a family member had a positive tuberculin skin (TB) test?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Was your child born in a country with a high rate of tuberculosis (places other than the United States, Canada, Australia, New Zealand, or Western European countries) like Mexico, South and Central America, Asia, India, and Eastern European countries? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Has your child traveled (had contact with resident populations) to a high risk country for more than 1 week?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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