12 months- well child care Name:_____

Household

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

Does your child attend daycare?	Yes	No

Development

Walks holding on to things like furniture?	Yes	No
Walking?	Yes	No
Stands alone?	Yes	No
Stacks at least 2 blocks?	Yes	No
Turns pages of books?	Yes	No
Drinks from cup?	Yes	No
Understands simple phrases?	Yes	No
Says “mama” and “dada” specific to parent	Yes	No
Plays with other children?	Yes	No
Child gets upset around strangers	Yes	No

Nutrition

Bottle feeding or breast feeding?	Bottle	Breast
Weaned from bottle?	Yes	No
Started whole milk	Yes	No
Well balanced diet with table and stage 3 foods?	Yes	No
Well water or city water?	Well	City

Bowel habits

How many stools a day?

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

Sleep Pattern___

Sleeps through night in own crib?	Yes	No

Safety

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

Miscellaneous

Any questions or concerns?	Yes	No

If yes, what are they

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?
- If born before 1/1/2015, lives in a 2004 "at-risk" zip code?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, 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 store or serve food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Was your child born in, or lived more than a year in a country other than the U.S.?
- Has your child been exposed to anyone with either active or a history of Tuberculosis disease?
- Is your child living in a house hold with anyone who is HIV Positive?
- Is your child part of a migrant worker family?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Blood Pressure _____

Vision Test: Left 20/ ___ Right 20/___

Hearing Test: