PEDIATRIC HEALTH MAINTENANCE – 12 Months

Parent Questionnaire

General

Do you have any concerns or questions you would like to discuss today?	☐ No	☐ Yes
If yes, please specify:		
Is your child in daycare or the care of another person outside parents?	☐ No	☐ Yes
Do you have any concerns about your child's vision or hearing?	☐ No	☐ Yes
Do your child's eyes ever appear to cross or drift apart?	☐ No	☐ Yes

Feeding and Sleeping

What is your baby fed?	☐ Breast milk	☐ Formula	☐ Milk	☐ Other		
Are you giving your child any vitamins?	☐ No	☐ Vitamin D	☐ Iron	☐ Other		
Does your child eat a good variety of foods (meat/protein, vegetables, grains, fruit)?					☐ Yes	☐ No
Does your child sleep through the night?					☐ Yes	☐ No
Does your child sleep with a bottle?					☐ No	☐ Yes

Development

Does your child wave "bye-bye"?	☐ Yes	☐ No
Does your child call a parent "mama" or "dada" or another special name?	☐ Yes	☐ No
Does your child look for things he sees you hide, like a toy under a blanket?	☐ Yes	☐ No
Does your child pull themself up to stand?	☐ Yes	☐ No
Does your child walk, holding on to furniture?	☐ Yes	☐ No
Does your child pick things up between thumb and pointer finger, like small bits of food?	☐ Yes	☐ No

Safety

Does your home have functioning smoke detectors?		☐ Yes	☐ No
Is your water heater turned down to below 120 degrees?	☐ Don't Know	☐ Yes	☐ No
Are all medicines and household products in a locked cabinet?		☐ Yes	☐ No
If you have stairs, are they blocked off at all times?		☐ Yes	☐ No
Do you leave your baby alone in the bathtub?		☐ No	☐ Yes
Are there any smokers in your home?		☐ No	☐ Yes
Do you have a firearm in your home?		☐ No	☐ Yes
If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them?		☐ Yes	☐ No
Are you afraid of your partner or anyone close to you?		☐ No	☐ Yes
Do you feel overly stressed or unsupported?		☐ No	☐ Yes

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME