code: PD005

{Office Name} Previsit Questionnaire

12 Month Visit

For us to provide you and your child with the best possible healthcare, we would like to know how things are going. Please answer all of the questions. Thank you.

First Name _____ **Last Name** _____ **Date of Birth** _____

What would you like to talk about today?

_____

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Support

- ☐ Ways to manage your child's behavior
- ☐ Finding time for yourself
- ☐ Parent/family community activities

Establishing Routines

- ☐ Nap time routines
- ☐ Bedtime routines
- ☐ Brushing teeth
- ☐ Starting family traditions

Feeding Your Baby

- ☐ Using a spoon and cup
- ☐ Healthy food choices
- ☐ How many meals or snacks a day
- ☐ How much your child should eat
- ☐ Change in appetite and growth
- ☐ Your child's weight

Finding a Dentist

- ☐ Your child's first dental checkup
- ☐ Brushing teeth twice daily
- ☐ Finger sucking, pacifiers, and bottles

Safety

- ☐ Home safety indoors and outdoors
- ☐ Car safety seats
- ☐ Water safety
- ☐ Gun safety
- ☐ Older siblings watching your child
- ☐ Foods that might cause choking

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit?

- ☐ Yes
- ☐ No
- ☐ Unsure

If yes, please describe:

_____

Hearing - Do you have concerns about how your child hears?

- [ ] Yes
- [ ] No
- [ ] Unsure

Hearing - Do you have concerns about how your child speaks?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Do you have concerns about how your child sees?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Does your child hold objects close when trying to focus?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Do your child's eyes appear unusual or seem to cross, drift, or be lazy?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Do your child's eyelids droop or does one eyelid tend to close?

- [ ] Yes
- [ ] No
- [ ] Unsure

Vision - Have your child's eyes ever been injured?

- [ ] Yes
- [ ] No
- [ ] Unsure

Lead - Does your child have a sibling or playmate who has or had lead poisoning?

- [ ] Yes
- [ ] No
- [ ] Unsure

Lead - Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months)renovated or remodeled?

- [ ] Yes
- [ ] No
- [ ] Unsure

Lead - Does your child live in or regularly visit a house or child care facility built before 1950?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Has a family member or contact had tuberculosis or a positive tuberculin skin test?

- [ ] Yes
- [ ] No
- [ ] Unsure

Tuberculosis - Is your child infected with HIV?

- [ ] Yes
- [ ] No
- [ ] Unsure

Oral Health - Do you know a dentist to whom you can bring your child?

- [ ] Yes
- [ ] No
- [ ] Unsure

Oral Health - Does your child's primary water source contain fluoride?

- [ ] Yes
- [ ] No
- [ ] Unsure

Does your child have any special health care needs?

- [ ] Yes
- [ ] No

If yes, please describe:

_____

Have there been any major changes in your family lately?

- [ ] Move
- [ ] Job change
- [ ] Separation
- [ ] Divorce
- [ ] Death in the family
- [ ] Any other changes?

Please describe any other changes:

_____

Does your child live with anyone who uses tobacco or spend time in any place where people smoke?

- [ ] Yes
- [ ] No

Your Growing and Developing Child

Do you have specific concerns about your child's development, learning, or behavior?

- [ ] Yes
- [ ] No

If yes, please describe:

_____

Check off each of the tasks that your child is able to do:

- [ ] Bangs toys together
- [ ] Waves bye-bye
- [ ] Tries to do what you do
- [ ] Stands alone
- [ ] Drinks from a cup
- [ ] Speaks 1 to 2 words
- [ ] Babbles
- [ ] Tries to make the same sounds you do
- [ ] Looks at things you are looking at
- [ ] Cries when you leave
- [ ] Hands you a book to read
- [ ] Follows simple directions
- [ ] Plays peekaboo