

One Year Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you. Please fill out **BOTH SIDES**

Can your child get himself to a standing position?	Yes	No	Unsure
Does your child take steps holding on to furniture?	Yes	No	Unsure
Does your child walk?	Yes	No	Unsure
Does your child pick up objects with the tips of the thumb and fingers?	Yes	No	Unsure
Does your child feed herself?	Yes	No	Unsure
Can you get your child to laugh?	Yes	No	Unsure
Does your child babble (talk with made up words/sounds)	Yes	No	Unsure
Does your child say dada or mama, with specific meaning?	Yes	No	Unsure
Does your child use any gestures (wave bye-bye, point)	Yes	No	Unsure
Does your child look at you when you call his or her name?	Yes	No	Unsure

Is your child completely weaned from the bottle? Yes No Unsure

Is your baby getting breast milk, formula, or other milk? Breast Formula Other milk

How much breast milk, formula or milk does your child drink in 24 hours? _____oz or _____feeds

How many ounces of juice does your child drink in 24 hours? _____oz

Does your child eat meat (such as fish, chicken, beef, or pork)? Yes No

Was your child born within 3 weeks of his or her due date? Yes No Unsure

Did your child weigh more than 5 pounds 8 ounces (2500 gm) at birth? Yes No Unsure

Does your child sleep through the night? Yes No Unsure

Do you usually use sunscreen for your child when outdoors? Yes No Unsure

Do you have the poison control number (800 222-1222) posted at home? Yes No Unsure

Are there guns at your home, or any home your child regularly visits? Yes No Unsure

Does your child have access to a home pool? Yes No Unsure

Do you have any other safety concerns at your home? Yes No Unsure

What are your concerns? _____

Over the past 2 weeks, has mom ever felt down, depressed, or hopeless? Yes No Unsure

Over the past 2 weeks, has mom felt little interest or pleasure in doing things? Yes No Unsure

PLEASE TURN OVER

Your Child's Name: _____

Who provides daytime care for your child? _____

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including fluoride? If so, please list below:

Risk Assessment for Lead Exposure:

Does your child live in or regularly visit a house or child care facility built before 1950? Yes No Unsure

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)? Yes No Unsure

Does your child have a sibling or playmate who has or did have lead poisoning? Yes No Unsure

Does your child take any imported home remedies or supplements? Yes No Unsure

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease? Yes No

Has a family member had a positive tuberculin skin test? Yes No

Was your child born in a high-risk country?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes NoHas your child traveled to (or had contact with people
who live in) a high-risk country for more than one week?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes NoDo you have any concerns about your child's development, or any
other concerns you would like to discuss with your provider? Yes No*If so, what are your concerns?*