12 MONTH OLD

"I'm one! Even though I am acting more independent, I need your help to understand and accept my emotions even more."

pediatrics NORTHWEST PS Mary Bridge Children's
www.pedsnw.net

Patient Name: _____

Person Filling Out Form: _____

Relationship to Patient: _____

CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

yes no Does your child take any medications (daily or as needed)? If so, please list: _____
yes no Has your child had any reactions to medications?
yes no Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes no Is your child in day care?
yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes no Has a parent or household member ever had a problem with alcohol or drug use?
yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

yes no Is your baby breastfeeding?
yes no Does your baby take a bottle?
yes no Does your baby drink anything other than milk and water? If so, what? _____
yes no Is your baby eating table foods?

PREVENTIVE HEALTH

yes no Does your child always ride in a rear facing car seat and in the backseat?
yes no Is your child using screen time for entertainment (TV, tablet, phone, movies, video games, etc.)?
yes no Does your child have outdoor time daily?
yes no Do you live in a home built before 1960 (possible lead exposure)?
yes no Does a family member frequently work with lead (car batteries, making stain glass, etc.)?
yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
yes no Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
yes no Have those alarms been checked in the past 12 months?
yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
yes no Has a family member or close contact had tuberculosis or had a positive test for tuberculosis?
yes no Was your child born in or traveled to a country for more than a week that may have a higher risk of tuberculosis and had contact with the resident population (countries outside of the United States, Canada, Australia, New Zealand, or Western European countries)?
yes no Is your child enrolled in WIC?

On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes no Eyes (crossing, not focusing, drainage, redness)
yes no Swallowing or eating
yes no Coughing, noisy or difficulty breathing
yes no Vomiting
yes no Stooling (diarrhea, constipation, or blood in the stools)
yes no Extremities (feet, legs, arms, hands)

DEVELOPMENT (please check the things that your child is currently doing)

Gross motor	[ ] Crawls [ ] Pulls to stand [ ] Cruises around furniture [ ] Stands alone
Fine motor	[ ] Pincer grasp (finger & thumb) [ ] Feeds self
Social	[ ] Plays peek-a-boo [ ] Points
Language	[ ] Mimics words [ ] Specific mama/dada [ ] Uses simple gestures
Cognitive	[ ] Looks at picture when named [ ] Follows 1 step directions [ ] Finds hidden objects easily