Reedsburg AREA MEDICAL CENTER Physicians Group

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Patient Questionnaire – 12 Month Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother	Stepparent	Grandmother	Aunt
	Father	Brother	Grandfather	Foster Parent
	Legal Guardian	Sister	Uncle	Caseworker
Lives With (please circle)	Mother	Stepparent	Grandmother	Aunt
	Father	Brother	Grandfather	Foster Parent
	Legal Guardian	Sister	Uncle	Caseworker
Interval Problems (please circle)	Caregiver depression	Lack of social support	Recent illness	
	Caregiver stress	Marital discord	Recent injury	
	Chronic caregiver stress at home			
Nutrition				
Milk Source (please circle)	Breastfeeding	Cow's Milk	Formula	
	Milk/Formula intake volume oz/day: _____			
Cereal				
Cereal Type (please circle)	Barley	Corn	Oat	Rice
Types of intake (please circle)	Cereals	Fish	Juices	Non-nutritional
	Eggs	Fruits	Meats	Vegetables
Difficulties with feeding? (please circle)	Yes	No		
Dental				
Has a dental home (please circle)	Yes	No	**Teething Symptoms** (please circle)	Yes No
Tooth Eruption (please circle)	Not evident	Beginning	In progress	Complete

Please see reverse side

Elimination	
Elimination Problems (please circle)	Colic Diarrhea Urinary Symptoms Constipation Gas
Sleep	
Sleep Location (please circle)	Crib Parent's Bed
How child falls asleep (please circle)	Bottle is in crib In caretaker's arms while feeding On own In caretaker's arms **Average sleep duration in hours: _____**

Safety/Environment			
Home is child-proofed (please circle)	Yes No Partially		
Smoking in home (please circle)	Yes No		
Working smoke alarms (please circle)	Yes No Don't know		
Working CO (carbon monoxide) alarms (please circle)	Yes No Don't know		
Car seat (please circle)	Yes No		
Screening			
Immunizations up-to-date (please circle)	Yes No	**Risk factors for tuberculosis** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes No	**Risk factors for lead toxicity** (please circle)	Yes No
Social			
Caregiver enjoys child (please circle)	Yes No		
Childcare location (please circle)	Child's home Daycare Another residence		
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider		
Days per week at daycare: _____ **Hours per day at daycare: _____**			

Growth and Development

Do you or your family/childcare provider have concerns about your baby's speech, learning, motor skills or behavior? (please circle)

Yes No

Does your child:

Have behavior that makes you concerned? (please circle)

Yes No

Look you in the eye for more than a second or two? (please circle)

Yes No

Get upset when parents or caregivers leave the room or are out of sight? (please circle)

Yes No

Say a word like “mama” or “dada” and mean “mommy” or “daddy”? (please circle)

Yes No

Understand his/her own name or pause when you say "no"? (please circle)

Yes No

Pick up small objects such as a Cheerio or other finger foods? (please circle)

Yes No

Pull self to a standing position? (please circle)

Yes No

Get self into a sitting position? (please circle)

Yes No

Point or use hands in other ways such as waving or clapping? (please circle)

Yes No

Walk with support? (please circle)

Yes No

Please see reverse side

Lead Screening

Does your Child have siblings or playmates with lead poisoning? (please circle)

Yes No

Enrolled in Medicaid or WIC? (please circle)

Yes No

Lives in or visits a home or building built before 1950? (please circle)

Yes No

Lives in a home or building built before 1978 with recent or ongoing renovations? (please circle)

Yes No