



ABC Pediatrics

Twelve Month Pre-visit Questionnaire

Patient Name _____

Date _____

Bathes (daily) (every other day)

Feeding Routine (circle one): Formula Feeding Breast feeding Whole Milk

Drinking from Sippy cup or bottle? _____ Balanced Diet? _____ Picky eater? _____

Comments: _____

of stools Daily _____ # of voids Daily _____

Type of water (bottled/well/city): _____ # of hours sleeping at ONE time _____

Developmental Milestones (circle all that apply)

- Crawls
- Drinks from a cup
- Feeds self
- Looks at pictures
- Pincer grasp (thumb/pointer)
- Points to 2 body parts
- Says Mama/dada
- Stands
- Walks holding on
- Waves Bye Bye
- Plays Pat-a-cake
- Stranger Anxiety

Lead Test Completed? YES NO

Any other questions or concerns you would like to discuss?

TB Screen	Has a family member or contact been diagnosed with TB?	YES	NO
	Was your child born in a country at high risk for TB?	YES	NO
	Has your child traveled to a country at high risk for TB?	YES	NO
Lead Risk	Does your child have a sibling or playmate that has had lead poisoning?	YES	NO
	Does your child live in or regularly visit a home built before 1978 that being renovated?	YES	NO
	Does your child live in or regularly visit a house or childcare facility built before 1950?	YES	NO

Weight _____ Temp _____ Height _____ Head Circumference _____