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_____ # 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_____