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_____

Current Dentist:_____ Current Daycare:_____

Developmental Milestones (circle all that apply)

☐ Saya dad or mom with meaning	☐ Uses one word other than mom or dad, or personal names	☐ Follows a verbal command that includes a gesture.	☐ Looks for hidden objects.
☐ Imitates new gestures.	☐ Drops objects in a cup.	☐ Picks up small objects	☐ Picks up food and eats it.
☐ Takes first independent steps.	☐ Stands without support	with 2-finger pincer grasp.	

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_____ GoCheck_____