



# Health Maintenance Questionnaire

# 12 MONTHS

PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_\_

PARENTS \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION		PHYSICIAN'S COMMENTS
<b>H I S T O R Y</b>	Describe any recent injuries or illnesses: _____	<input type="checkbox"/> Feeding refusal / Simplify feeding needs <input type="checkbox"/> Time-in and Time-out  <input type="checkbox"/> Discussed risks of 2 <sup>nd</sup> hand smoke. <input type="checkbox"/> Prescribed fluoride vitamins.
	List medications taken routinely: <input type="checkbox"/> none	
	Note any new stresses in the family: _____	
	Is your child in day care? <input type="checkbox"/> No <input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other: How many kids? _____	
<b>N U T R I T I O N</b>	Are there any smokers in your child's home or daycare? <input checked="" type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room	
	Does your child drink water that is fluoridated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
	How many ounces per day of Whole milk _____ Juice _____ How many servings per day of Meat _____ Fruit _____ Veggies _____	
	<b>Y N</b> <input checked="" type="checkbox"/> Are meals and snacks fairly well scheduled? <input checked="" type="checkbox"/> Has your child tolerated all foods introduced? <input checked="" type="checkbox"/> Is s/he finger feeding a variety of foods, mostly from the table? <input checked="" type="checkbox"/> Does s/he drink from a cup? How many bottles does baby take per day? _____ ----- If nursing, how many times per day? Are you pumping breast milk? _____	
Does your child pass stools without problems? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<b>Shaded items are new for the 12 mo check-up.</b> <b>GENERAL FEEDING RECOMMENDATIONS</b> <input type="checkbox"/> Iron fortified rice cereal, 2 tbsp/day. <input type="checkbox"/> Increasing appetite fluctuations. <input type="checkbox"/> Whole milk until age 2. <input type="checkbox"/> Limit juices. <input type="checkbox"/> Wean from bottle. <input type="checkbox"/> Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins. <input type="checkbox"/> Fluoride and Vitamins only if prescribed. <b>BREAST FEEDING RECOMMENDATIONS</b> <input type="checkbox"/> Should be sleeping through the night. <input type="checkbox"/> May follow lower percentile on weight growth curve. <input type="checkbox"/> Continue nursing as long as you both desire. <input type="checkbox"/> When ready, wean gently and gradually. <input type="checkbox"/> 4-12 feedings in 24 hrs is typical. <input type="checkbox"/> Nursing for comfort is common.

PHYSICAL EXAM		LAB	IMMUNIZATIONS
Ht _____ Wt _____ HC _____ VS: _____		<input type="checkbox"/> Hgb	<input checked="" type="checkbox"/> Given at Health Department
Check if normal:	<input type="checkbox"/> Nose <input type="checkbox"/> Lungs <input type="checkbox"/> Back <input type="checkbox"/> Mouth <input type="checkbox"/> Heart <input type="checkbox"/> Hips <input type="checkbox"/> Eyes/Red reflexes <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Extremities <input type="checkbox"/> Ears <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Skin <input type="checkbox"/> Chest <input type="checkbox"/> Genitalia <input type="checkbox"/> Neurologic	<input type="checkbox"/> Lead	Shots up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> PPD placed	Any previous side effects? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Other: _____	If yes, what? _____
			<input type="checkbox"/> DTaP <input type="checkbox"/> HepB <input type="checkbox"/> IPV <input type="checkbox"/> Hib <input type="checkbox"/> Comvax <input type="checkbox"/> MMR <input type="checkbox"/> Prevnar <input type="checkbox"/> Varivax Other: _____

ASSESSMENT	PLAN
1. <input type="checkbox"/> NORMAL GROWTH and DEVELOPMENT. More information on other side.	1. <input type="checkbox"/> Follow up at 15 months for Health Review. <input type="checkbox"/> Anticipatory handouts given.
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Do you have concerns about your child's vision or hearing?  Yes  No

**12 month**

DEVELOPMENTAL ASSESSMENT	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's development?	
M O T O R	<b>Y N</b> <input type="checkbox"/> Does baby pull to a stand? <input type="checkbox"/> Does s/he cruise around furniture? <input type="checkbox"/> Does your baby walk? <input type="checkbox"/> with help <input type="checkbox"/> alone <input type="checkbox"/> Does s/he pick up small items with thumb and finger? <input type="checkbox"/> Does s/he put one object inside of another?
	<b>Y N</b> <input type="checkbox"/> Does s/he say "MAMA and DADA" and try to imitate words? <input type="checkbox"/> Do you repeat his/her words using proper enunciation? <input type="checkbox"/> Do you encourage speech by talking and singing? <input type="checkbox"/> Do you read books with real life pictures? <input type="checkbox"/> Does your baby wave "bye-bye"? <input type="checkbox"/> Do you limit TV to less than 2 hours per day?
	<b>Y N</b> <input type="checkbox"/> Does baby look for a dropped or hidden object? <input type="checkbox"/> Does s/he play peek-a-boo, pat-a-cake and so-big? <input type="checkbox"/> Does baby come when called? <input type="checkbox"/> Do you encourage your baby to play alone to foster independence?

BEHAVIOR RECOMMENDATIONS	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Are you concerned about your child's behavior?	
If these were reviewed previously, check this box. <input type="checkbox"/> You may skip to the "Sleep" box.	
S L E E P	<b>Y N</b> <input type="checkbox"/> Is your baby becoming more independent? (normal) <input type="checkbox"/> Is your discipline consistent? (very important) <input type="checkbox"/> Do you show affection regularly? <input type="checkbox"/> Do you praise good behavior frequently? (time-in) <input type="checkbox"/> Do you remove attention when doing unacceptable behavior? <input type="checkbox"/> Do you set limits and choose your battles wisely? <input type="checkbox"/> Do you occasionally say "no"? <input type="checkbox"/> Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers? <input type="checkbox"/> Do you try to ignore tantrums? (very typical)
	<b>Y N</b> <input type="checkbox"/> Does your baby sleep well? (Separation anxiety may cause sleep problems.) <input type="checkbox"/> Do you maintain a bedtime routine? <input type="checkbox"/> Do you offer a security toy/blanket for awakenings? <input type="checkbox"/> Does your baby nap twice daily? (typical) <input type="checkbox"/> Are you OK with your baby's use of self-comforting behaviors? <input type="checkbox"/> thumb sucking <input type="checkbox"/> pacifier <input type="checkbox"/> favorite object? <input type="checkbox"/> None <input type="checkbox"/> Do you avoid giving baby a bottle in the crib? (cavities)
	Where does baby usually sleep?

SAFETY AWARENESS	
Please review the shaded items, which are new for the 12 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/> You may skip to the "TB Risk" box.	
<b>Y N</b> <input type="checkbox"/> Is the car seat in the back seat? → <input type="checkbox"/> Do you keep your child away from machinery/tractors/mowers? <input type="checkbox"/> Do you monitor him/her for climbing into dangerous situations? <input type="checkbox"/> Do you have the Poison Control Center's number handy? <input type="checkbox"/> Are medications, poisons and plants out of reach? <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub? <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets?	<div style="border: 1px dashed black; padding: 5px;">           If baby is outgrowing the infant carrier car seat (usually around 20 lbs) switch to a "convertible" car seat. It must still rear face if baby is less than 20 lbs. It can forward face if baby is over 20 lbs AND over 1 yr old.         </div> <b>Y N</b> <input type="checkbox"/> Do you have gates to guard the stairs? <input type="checkbox"/> Are sharp table edges protected? <input type="checkbox"/> Do you keep small items out of reach which baby could choke on? <input type="checkbox"/> Do you check toys for breakage that may be hazardous? <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child? <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> Do you keep your curling iron out of reach? <input type="checkbox"/> Do you limit sun exposure? <input type="checkbox"/> Have you inserted electrical outlet covers? <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?

TUBERCULOSIS (TB) RISK	
If you reviewed these TB risks previously and believe your child is still <b>not</b> at risk, check this box. <input type="checkbox"/> Skip to the "Lead Risk" box.	<b>Y N</b> <input type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test? <input type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America? <input type="checkbox"/> Is anyone living in your house infected with HIV? <input type="checkbox"/> Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers. <input type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?
	<div style="border: 1px solid black; padding: 5px;">             TB Risk:  <input type="checkbox"/> High <input type="checkbox"/> Low           </div>

LEAD RISK	
If you reviewed these Lead risks previously and believe your child is still <b>not</b> at risk, check this box. <input type="checkbox"/>	<b>Y N</b> <input type="checkbox"/> Does your child live in or visit a house built before 1978? <input type="checkbox"/> Is there a sibling or playmate with lead poisoning? <input type="checkbox"/> Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways? <input type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead? <input type="checkbox"/> Does your child have an unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?
	<div style="border: 1px solid black; padding: 5px;">             Lead Risk:  <input type="checkbox"/> High <input type="checkbox"/> Low           </div>

Who answered the above questions? \_\_\_\_\_ Thank you for helping us help you and your child!!  
**Please put this paper in the box hanging outside the door so that we know you are finished!**