

Name: _____ Date of birth: _____

Health Status Questionnaire – 12 Months

Baby lives with: mother father both parents other: _____

Childcare: daycare babysitter stays at home other: _____

Breastfeeding? Y N Every ____ hours, For ____ minutes per side

Formula feeding? Y N Formula: _____

____ oz every ____ hours, ____ oz total 24 hours

____ Baby food ____ finger food ____ whole milk

Any problems feeding? Y N _____

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Development concerns: none speech motor social cognitive vision hearing

Does your baby:

Stand alone for 2-3 seconds? Y N

Walk for a short distance? Y N

Stoop down and stand back up? Y N

Play ball? Y N

Put items in a cup? Y N

Use thumb and index finger to pick up small things(pincer grasp)? Y N

Drink from a cup? Y N

Say “mama” “dada”? Y N

Indicate wants or point to things? Y N

Say 1-3 words? Y N

Play ball? Y N

Wave “bye-bye”? Y N

Car seat use: Y N Smoke detectors: Y N

Sunscreen: Y N Fire extinguishers: Y N

Insect protection: Y N Firearms/guns in house: Y N

Home child proofed: Y N Locked away: Y N

Passive smoke exposure: Y N

Lead Exposure Questions:

Does your child live in or regularly visit a house or child care facility built before 1950? Y N

Does your child live in or regularly visit a house or child care facility built before 1978 with peeling or chipping paint? Y N

Does your child have a sibling or playmate who has or had lead poisoning? Y N

Tuberculosis (Tb) Screen Questions:

Has your child ever received BCG (Tb vaccine given in some foreign countries)? Y N

Has there ever been tuberculosis/Tb in any household member? Y N

Was your child born or traveled for longer than 2 weeks to a country at high risk for Tb (countries other than Canada, Australia, New Zealand or western Europe)? Y N

Do you have any concerns about your baby? _____