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
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? _____________________________________

Updated 5/4/18