OBERLIN ROAD PEDIATRICS

Well Child Check: 12 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? □ No □ Yes: _____

Does your baby have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does your baby see any specialists outside of ORP? □ No □ Yes: _____

Does your water contain fluoride? (City water contains fluoride) □ Yes □ No

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis result? □ No □ Yes

Was your child or any household member born in or traveled to a high-risk country (This includes countries in Africa, Asia, Latin America, and Eastern Europe)? □ No □ Yes

Nutrition:

What type(s) of milk is your child drinking? □ Whole milk □ Breast milk □ Formula □ Other_____

Have you started any transition from bottles/breast to sippy cups? □ Yes □ No

Are they usually getting 2-3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

Are they usually drinking MORE than 24 oz of formula/milk a day? □ No □ Yes

Are they eating iron rich foods daily (meat, beans, iron vitamin, cheerios/cereal)? □ Yes □ No

Does your child….

Play with you like pat a cake?	Yes	No
Wave bye-bye?	Yes	No
Call parent mama or dada?	Yes	No
Understand no by pausing briefly?	Yes	No
Put something in a container like a block in a cup?	Yes	No
Look for things he sees you hide, like a toy under a blanket?	Yes	No
Pull to a stand?	Yes	No
Walk holding onto furniture?	Yes	No
Drink from a cup without a lid as you hold it?	Yes	No
Pick things up like between the thumb and the index finger?	Yes	No

Who lives at home with your child? _____

Are parents: single married divorced separated

Who takes care of your child during the day? _____

Have there been major changes lately in your baby's or family's life? _____
Will your child travel internationally prior to their 2nd birthday? If yes, when and where: _____

If your baby has teeth, are you brushing 2x a day with fluoridated toothpaste?	Yes	No
Does your child try feeding herself using a spoon?	Yes	No
Do you give your child small, hard foods such as peanuts and popcorn?	No	Yes
Do you give your child round foods such as hot dogs, raw carrots, whole grapes, and grape tomatoes?	No	Yes
Does your child decide what and how much to eat?	Yes	No
Are they eating vegetables and fruits?	Yes	No
Are they eating foods rich in protein, such as eggs, beans, lean meat, chicken, or fish?	Yes	No
Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	No	Yes
If your child is upset, do you help distract him using another activity, book, or toy?	Yes	No
Does your family regularly make time for reading, playing, and talking together?	Yes	No
Is a TV, computer, or tablet on in the background when your baby is in the room?	No	Yes
Do you eat as a family?	Yes	No
Does your child have regular mealtimes and snack times?	Yes	No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?	Yes	No
Is your baby fastened securely in a rear facing car seat in the back seat every time they ride in the car?	Yes	No
Do you have a gate at the top and bottom of all stairs in your home?	Yes	No
Is the mattress in your child's crib set on the lowest setting to prevent falls?	Yes	No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reach?	Yes	No
Do all your electrical outlets have covers?	Yes	No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?	Yes	No
Do you keep your child away from the stove, fireplaces, and space heaters?	Yes	No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	Yes	No
Do you always stay within arm's reach of your baby when on the changer, bed or in/near water?	Yes	No
Do you have a swimming pool, pond, or lake in or near your home?	No	Yes
Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes