

12-Month-Old Well Child Visit

Child's Name: _____ Child's Age: _____ Date: _____

Person completing the form _____ Relationship to the patient _____

Has your child had any illnesses, hospitalizations, or surgeries since last visit here? (YES) (NO)

Nutrition:	Yes	No
Is your child drinking whole milk, limited to no more than 20 ounces per day?	<input type="checkbox"/>	<input type="checkbox"/>
Have you weaned your child from the bottle?	<input type="checkbox"/>	<input type="checkbox"/>
Is juice or sugary drinks limited to 0-1 servings per day?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child eat a variety of fruits/vegetables/dairy/meat?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child regularly take a supplement that contains vitamin D?	<input type="checkbox"/>	<input type="checkbox"/>
On average, does your child eat fast food one or more times per week?	<input type="checkbox"/>	<input type="checkbox"/>

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

Preventative Health/Risk Factors:	Yes	No
How many hours of TV or videos is your child exposed to per day? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child always ride in a car seat, in the back seat, facing backwards?	<input type="checkbox"/>	<input type="checkbox"/>
Do you, anyone in your home, or anyone who cares for your child smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child had close contact with anyone who has tuberculosis (TB), or is at high risk for TB (visited Africa, Asia, Latin America, Caribbean Country, been homeless or jailed, IV user, HIV positive)?	<input type="checkbox"/>	<input type="checkbox"/>
Is your water heater set to less than 120 degrees?	<input type="checkbox"/>	<input type="checkbox"/>

Oral Health:	Yes	No
Have you found a dentist for your child yet?	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep well, without snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about how your child is learning, developing and behaving?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in enrolling your child in daycare?	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> • If yes, do you need assistance to find a suitable program? 	<input type="checkbox"/>	<input type="checkbox"/>

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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Developmental Surveillance:

Social/Emotional Development:	Yes	No
Waves bye-bye?	<input type="checkbox"/>	<input type="checkbox"/>
Tries to do what you do?	<input type="checkbox"/>	<input type="checkbox"/>
Cries when you leave?	<input type="checkbox"/>	<input type="checkbox"/>
Plays peek-a-boo?	<input type="checkbox"/>	<input type="checkbox"/>
Hands you a book to read?	<input type="checkbox"/>	<input type="checkbox"/>

Communicative Development:	Yes	No
Speaks 1-2 words?	<input type="checkbox"/>	<input type="checkbox"/>
Tries to make the same sounds as you?	<input type="checkbox"/>	<input type="checkbox"/>
Looks at things you are looking at?	<input type="checkbox"/>	<input type="checkbox"/>

Cognitive Development:	Yes	No
Follows simple directions?	<input type="checkbox"/>	<input type="checkbox"/>

Physical Development:	Yes	No
Bangs toys together?	<input type="checkbox"/>	<input type="checkbox"/>
Pulls to stand?	<input type="checkbox"/>	<input type="checkbox"/>
Stands alone?	<input type="checkbox"/>	<input type="checkbox"/>

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