KAISER PERMANENTE®

# Well-Visit Questionnaire
## Children Age 12 Months

**Your child is 12 months old!**

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

| **Do you have specific concerns? Check all that apply, then briefly describe your concern:** | |
|---|---|
| ☐ Well Visit ☐ Allergies ☐ Cold/flu ☐ Constipation ☐ Cough ☐ Development ☐ Earache ☐ Fever<br>☐ Growth/nutrition ☐ Injury ☐ Rash ☐ Red eyes ☐ Sore throat ☐ Speech ☐ Temper ☐ Vaccines ☐ Vomiting<br>☐ Other (please explain):_____<br>Briefly describe your concern:_____ | |
| **Health Changes** | |
| Has your child received any specialty or emergency care since the last visit?<br>If Yes, please describe: _____ | ☐ Yes ☐ No |
| Has your child or anyone in the family developed a new health condition or died?<br>Include parents, brothers, sisters, grandparents, aunts, uncles or cousins.<br>If Yes, please describe: _____ | ☐ Yes ☐ No |
| **Nutrition, Feeding and Supplements – Tell us about what your child eats.** | |
| My child eats (check all that apply):<br>☐ Breastmilk ☐ Formula ☐ Cow's milk ☐ Solid food, like purees or soft finger foods | |
| My child eats iron-rich foods, like pureed meat, beans, iron-fortified cereal: | ☐ Yes ☐ No |
| My child eats fruits or vegetables at least 2 times per day: | ☐ Yes ☐ No |
| My child drinks something other than milk/formula or water in their bottle:<br>If yes, what else do they drink in the bottle? _____ | ☐ Yes ☐ No |
| Please list any other vitamins, supplements, or over-the-counter medicines you give your child:<br>_____ | |
| **Dental Health** | |
| Do you clean your child's teeth every day? | ☐ Yes ☐ No |
| Has your child seen a dentist? | ☐ Yes ☐ No |
| Does your water source have fluoride? | ☐ Yes ☐ No<br>☐ I don't know |
| **Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.** | |
| **My child:** | |
| Has a word for me that is specific ("mama" or "dada"): | ☐ Yes ☐ No |
| Understands simple commands, like "clap your hands" or "come here": | ☐ Yes ☐ No |
| Tells me that they want something by pointing at it: | ☐ Yes ☐ No |
| Walks alone, or with support (holding one hand or furniture): | ☐ Yes ☐ No |
| Picks up small objects between their thumb and pointer finger: | ☐ Yes ☐ No |
| Imitates me: | ☐ Yes ☐ No |

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|---|---|
| **Vision** | |
| My child's eyes track together and do not cross or wander: | ☐ Yes ☐ No |
| My child's eyes are the same color (both eyes and within each eye): | ☐ Yes ☐ No |
| **Hearing** | |
| My child hears and responds to their name: | ☐ Yes ☐ No |
| Has anyone in the family (related by blood) lost their hearing?<br>If yes, please describe who lost their hearing and at what age: _____ | ☐ Yes ☐ No |
| **Sleep** | |
| My child can usually fall asleep on their own and sleep through the night: | ☐ Yes ☐ No |
| **Safety** | |
| My child rides in a rear-facing car seat in the back seat of the car for every car ride: | ☐ Yes ☐ No |
| We have gates across stairs and safety guards on windows: | ☐ Yes ☐ No |
| We have cleaning supplies, medicines, and matches locked away: | ☐ Yes ☐ No |
| My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets): | ☐ Yes ☐ No |
| The buildings where my child lives or regularly visits were built after 1978 or, if built before 1978, have not been renovated in the past 6 months and do not have peeling paint: | ☐ Yes ☐ No |
| We avoid giving my child choking hazards, like hard, round, or sticky food, balloons, small toys or other objects: | ☐ Yes ☐ No |
| **Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.** | |
| Do you have concerns for low mood, depression, or anxiety in yourself or your partner? | ☐ Yes ☐ No |
| What is your plan for childcare?<br>☐ Home with parent ☐ Family member ☐ Nanny or Sitter ☐ Childcare center | |
| Do you need assistance finding affordable and safe childcare? | ☐ Yes ☐ No |
| **Is there anyone who lives in your home or cares for your child who:** | |
| - Smokes or vapes tobacco or marijuana: | ☐ Yes ☐ No |
| - Uses prescription pain medication: | ☐ Yes ☐ No |
| - Uses other drugs: | ☐ Yes ☐ No |
| - Consumes alcohol more than an occasional drink (a beer or glass of wine at night): | ☐ Yes ☐ No |
| **Within the past 12 months, have you:** | |
| - Run out of food or been worried your food would run out before there was money to buy more? | ☐ Yes ☐ No |
| - Worried about housing or had to move? | ☐ Yes ☐ No |
| - Had difficulty getting other supplies and services you need to care for your child?<br>Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation. | ☐ Yes ☐ No |

NOT TO BE FILED IN THE MEDICAL RECORD



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