



Woodinville Pediatrics 12 Month Questionnaire

Patient Name: _____ Date: _____

Parental concerns this visit: _____

Current Medications: _____

Current Allergies: _____

Family

Concerns about maternal depression ___yes ___no

Parents working outside home ___mother ___father

Child Care ___yes ___no Type _____

Changes since last visit _____

Diet

Milk _____

Type _____

Milk Amount/Time _____

Solid Food Comments _____

Source of water _____ Vitamins/Fluoride _____

Bowel/Bladder

Stool Concerns ___yes ___no

Stool Consistency ___hard ___soft

Urination Concerns ___yes ___no

Sleep

Back sleeping ___yes ___no

Location ___co-sleep ___crib ___co-sleep & crib

Duration ___ < 3 hrs ___ 3-6 hrs ___ > 6 hrs

Tobacco Exposure ___yes ___no

Behavior Concerns ___yes ___no

Activity (play time, no TV) _____

Development

Social Emotional: ___ Stranger Anxiety ___ Seeks parent for comfort

Communication: ___ Imitates sounds

___ Points out objects

Cognitive: ___ Peekaboo ___ Object permanence ___ Looks at books

Physical : ___ Sits well ___ crawls ___ Pulls to feet with support

Additional comments: _____
