# 10-12 Month Pre-Visit Questionnaire

***Instructions:*** *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

## General Health

| | | | |
|---|---|---|---|
| 1 | Do you have any concerns about your child's health? | NO | YES |
| 2 | Do you have any concerns about managing your child's behavior? | NO | YES |
| 3 | Has your child had any problems with shots or immunizations? | NO | YES |
| 4 | Does your child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)? | NO | YES |

## Feeding/Nutrition

| | | | | |
|---|---|---|---|---|
| 5 | Is your child breastfeeding? | YES | NO | Never breastfed |
| | a How often? | | | |
| 6 | Is your child drinking formula or milk well? | YES | NO | |
| | a Which kind of milk or formula? | | | |
| 7 | Is your child eating three meals of solid food per day? | YES | NO | |
| 8 | Is your child feeding him or herself? | YES | NO | |
| 9 | Can your child drink from a sippy cup? | YES | NO | |
| 10 | Are you weaning from the bottle? | YES | NO | |
| 11 | Does your child drink juice or other sweetened drinks? | NO | YES | |
| 12 | Do you give your child any vitamins or supplements? | NO | YES | |

## Oral Health

| | | |
|---|---|---|
| 13 Are cavities a problem for you or anyone in your family? | NO | YES |
| 14 Does your child sleep with a bottle? | NO | YES |
| 15 Does your child breast or bottle-feed during the night? | NO | YES |
| 16 Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your child's teeth and gums 2 times per day? | YES | NO |
| 17 Do you have a dentist for your child? | YES | NO |
| 18 Does your water contain fluoride or is your child on a fluoride supplement? | YES | NO |

## Elimination

| | | |
|---|---|---|
| 19 Does your child have any problems with bowel movements (pooping)? | NO | YES |

## Activity/Exercise/Screen time

| | | |
|---|---|---|
| 20 Does your child have screen time (smartphone, tablet, TV)? | NO | YES |
| 21 Do you play with and read to your child every day? | YES | NO |
| 22 Does your child get supervised floor time every day? | YES | NO |

## Sleep

| | | |
|---|---|---|
| 23 Does your child sleep through the night? | YES | NO |
| 24 Do you have a bedtime routine? | YES | NO |

## Social Stressors

| | | | |
|---|---|---|---|
| 25 Do you feel that you receive the support you need? | YES | NO | |
| 26 Have there been any major changes or stresses in your family recently? | NO | YES | |
| 27 Within the past 12 months have you worried that your food would run out before you got money to buy more? | NO | YES | SOMETIMES |
| 28 Within the past 12 months did you run out of food and you didn't have money to get more? | NO | YES | SOMETIMES |
| 29 Do you have any worries or concerns about childcare? | NO | YES | |

## Development
## (If you are completing the Ages and Stages questionnaire please skip this section)

| | | | |
|---|---|---|---|
| 30 | Does your child point when he/she wants something or is interested in something | YES | NO |
| 31 | Does your child babble, copy words you say, and make sounds? | YES | NO |
| 32 | Does your child say one or two words? | YES | NO |
| 33 | Can your child follow simple directions? | YES | NO |
| 34 | Does your child give you a book to read? | YES | NO |
| 35 | Does your child wave bye-bye and play peek-a-boo? | YES | NO |
| 36 | Does your child bang toys together? | YES | NO |
| 37 | Does your child cry when you leave? | YES | NO |
| 38 | Does your child eat finger foods with thumb and forefinger (pincer)? | YES | NO |
| 39 | Does your child walk well or with a little help? (like holding onto your fingers) | YES | NO |
| 40 | Can your child creep up stairs? | YES | NO |

## Lead

| | | | |
|---|---|---|---|
| 41 | Is your child regularly in a house built before 1978? | NO | YES |
| a | Is there any peeling or chipping paint? | NO | YES |
| b | Has there been any recent or ongoing remodeling or do you plan to do any remodeling? | NO | YES |
| 42 | Does your child have a brother, sister, or playmate who ever had lead poisoning? | NO | YES |

## Safety

| | | |
|---|---|---|
| 43 Do you always stay close enough to touch your child when he or she is in the bath? | YES | NO |
| 44 Do you keep furniture away from windows or use window guards? | YES | NO |
| 45 Does your child wear any jewelry (including necklaces)? | NO | YES |
| 46 Do you have a gate on your stairs? | YES | NO |
| 47 Is the crib mattress at the lowest position? | YES | NO |
| 48 Do you hold or carry hot liquids around your child? | NO | YES |
| 49 Does your child ride in a rear-facing safety seat, in the back seat? | YES | NO |
| 50 Does anyone smoke or vape around your child | NO | YES |
| 51 Do you have working smoke and carbon monoxide detectors in your home? | YES | NO |
| 52 Are you using a shade or sunscreen if your child is in the sun more than 10 minutes? | YES | NO |
| 53 Do you keep plastic bags and latex balloons away from your child? | YES | NO |
| 54 Is your water heater turned to below 120 degrees? | YES | NO |
| 55 Do you have barriers around space heaters, wood stoves, etc.? | YES | NO |
| 56 Are all of your household cleaners, chemicals, and medicines locked up? | YES | NO |
| 57 Do you have the number for Poison Control? | YES | NO |
| 58 Is there a swimming pool, pond, or lake near your home? | NO | YES |
| 59 Is there a gun in the home? | NO | YES |
| a Is it locked or in a safe with the ammunition stored separately? | YES | NO |

## Tuberculosis

| | | |
|---|---|---|
| 60 Has a family member or contact had tuberculosis disease (TB)? | NO | YES |
| 61 Has a family member ever had a positive TB skin test (PPD)? | NO | YES |
| 62 Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)? | NO | YES |
| 63 Has your child traveled to a high-risk country for more than a week? | NO | YES |

## Review of Systems

| | | |
|---|---|---|
| 64 Do you have any concerns about your child's hearing? | NO | YES |
| 65 Do you have any concerns about your child's vision? | NO | YES |
| 66 Does your child ever look cross-eyed? | NO | YES |