12 Month Well Child Check Name_____

Allergies_____Current Meds_____

Is your baby healthy?	**Yes**	**No**_____
Has your baby had any injuries?	No	Yes_____
Does your baby have any problem with stools or urinating?	**No**	**Yes**_____
Does your baby have any problem with sleep?	No	Yes_____
Does your baby have any feeding problems?	No	Yes_____
If breastfeeding, how often is your baby nursing?		_____
Does your baby drink whole milk? If so, how many oz/day? _____		
How many meals per day does your baby eat?		_____
Is your baby drinking from a cup or sippy cup?	Yes	No_____
Does your baby take a vitamin?	Yes	No
Is there Fluoride in your drinking water? (city water=yes)	Yes	No
Does your home have a safe, adequate heat source?	Yes	No
Does your family eat a balanced diet?	**Yes**	**No**
Does your baby have a well-rounded diet?	Yes	No_____
Has there been any recent change to your family structure?	No	Yes_____
Does anyone in your household smoke?	No	Yes
Is your baby in childcare?	No	Yes_____
Have you begun to wean your baby from the bottle?	*Yes*	*No*
Does your baby take naps?	*Yes*	*No*_____
Are you familiar with the 5-3-2-1-0 Healthy Lifestyles?	*Yes*	*No*
Does your baby ride in a rear facing car seat?	*Yes*	*No*

*Do you have any other concerns?*_____

Development (Do not complete if given Ages and Stage Questionnaire)

Does your baby say 1 to 3 words?	Yes	No
Does your baby pull to stand?	Yes	No
Does your baby stand alone?	Yes	No
Does your baby walk?	Yes	No
Does your baby use his/her index and thumb to pick up small items?	Yes	No
Does your baby use his/her index finger to point?	Yes	No
Does your baby bang two blocks together?	Yes	No
Does your baby look for dropped or hidden items?	Yes	No
Does your baby feed him/herself?	Yes	No
Does your baby drink from a sippy cup or cup?	Yes	No
Does your baby wave bye-bye?	Yes	No
Does your baby understand No?	Yes	No
Does your baby play peek-a-boo?	Yes	No