OPTUM®

Department of Pediatrics
1-719-522-1134 TTY **711**

# Well-check questionnaire

## 12 month well-check

**Patient name:** _____ **DOB:**_____ **Today's date:** _____

**Medications:**_____ **Allergies:** _____

**Mother's maiden name:** _____

# Of wet diapers a day:_____ # Of stools a day: _____

| | | |
|---|---|---|
| Is your child drinking whole milk? | ☐ No | ☐ Yes |
| Does your child eat primarily table foods? | ☐ No | ☐ Yes |
| Do you offer fruits and vegetables daily? | ☐ No | ☐ Yes |
| Do you limit daily juice intake and sugar/sweets? | ☐ No | ☐ Yes |
| Do you give your child any soda? | ☐ No | ☐ Yes |
| Does your child eat fast food? | ☐ No | ☐ Yes |
| Is your child sleeping in a crib or a bed? _____ | | |
| Does your child watch TV or videos? | ☐ No | ☐ Yes |
| Is your child always in a car seat when riding in a vehicle? | ☐ No | ☐ Yes |
| Is your hot water heater turned down to 120? | ☐ No | ☐ Yes |
| Does your home have smoke and carbon monoxide detectors? | ☐ No | ☐ Yes |
| Is your child exposed to secondhand smoke at home, in cars or at daycare? | ☐ No | ☐ Yes |
| Do you have outlet protectors and safety gates? | ☐ No | ☐ Yes |
| Do you know what to do if your baby chokes? | ☐ No | ☐ Yes |

**Does your baby:**

| | | |
|---|---|---|
| Stand alone and try to walk? | ☐ No | ☐ Yes |
| Clap and wave bye-bye? | ☐ No | ☐ Yes |
| Drink from a sippy cup? | ☐ No | ☐ Yes |
| Babble and say mama, dada? | ☐ No | ☐ Yes |
| Follow simple directions? | ☐ No | ☐ Yes |
| Use index finger to point to things? | ☐ No | ☐ Yes |
| Have any eye crossing? | ☐ No | ☐ Yes |

**Is your baby:**

| | | |
|---|---|---|
| Quick to agitation? | ☐ No | ☐ Yes |
| Difficult to soothe? | ☐ No | ☐ Yes |
| Hitting, biting, screaming or throwing tantrums? | ☐ No | ☐ Yes |

Any questions or concerns: _____