Pediatric Health Maintenance: 12 Months

Parent Questionnaire

Virginia Mason

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

Specific Concerns/ Questions for Visit

General Health		☐ I'd like to discuss
☐ Yes	☐ No	Is your child in daycare or the care of a babysitter?
☐ Yes	☐ No	Do you have concerns about your child's vision or hearing?
☐ Yes	☐ No	Do your child's eyes appear to cross or drift apart?

Feeding and Sleeping		☐ I'd like to discuss
How is your child fed?		☐ Breast ☐ Bottle ☐ Cup
Any vitamins?		☐ No ☐ Vitamin D ☐ Iron
☐ Yes	☐ No	Does your child eat a good variety of foods (meat, vegetables, grains, and fruit)?
☐ Yes	☐ No	Does your child sleep through the night?
☐ Yes	☐ No	Does your child sleep with a bottle?

Development		☐ I'd like to discuss
☐ Yes	☐ No	Does your child respond to his or her name?
☐ Yes	☐ No	Does your child stand briefly without holding on?
☐ Yes	☐ No	Does your child look when you point at an object?
☐ Yes	☐ No	Does your child enjoy playing "peek-a-boo"?
☐ Yes	☐ No	Does your child wave "bye-bye"?
☐ Yes	☐ No	Does your child feed himself or herself using their fingers?

Safety		☐ I'd like to discuss
☐ Yes	☐ No	Does your child ride in a car seat, in the back seat of car?
☐ Yes	☐ No	Does your home have functioning smoke detectors?
☐ Yes	☐ No	Is your water heater turned down to below 120 degrees? ☐ Don't Know
☐ Yes	☐ No	Are all medicines and household products in a locked cabinet?
☐ Yes	☐ No	If you have stairs, are they blocked off at all times?
☐ Yes	☐ No	Do you leave your baby alone in the bathtub?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 12 Months form.

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME & ID #

Lead Screening Questionnaire

Virginia Mason

First & Last Name: _____

Preferred Name: _____

Date of Birth: _____

Please check any boxes if you answer YES

- ☐ Do you live in or regularly visit any house built before 1950?
- ☐ Do you live in or regularly visit any house built before 1978 with recent or ongoing renovations?
- ☐ Does your family qualify as low income? (less than 130% of the poverty level)
- ☐ Does your child have a sibling or frequent playmate with elevated blood lead level?
- ☐ Is your child a recent immigrant, refugee, foreign adoptee, or in foster care?
- ☐ Do any parent or caregivers work professionally or recreationally with lead?

  Remodeling and demolition; painting; works in or visits gun ranges; mining; battery recycling; makes lead fishing weights or shotgun pellets; hobbies involving stained glass, pottery, soldering, or welding.

- ☐ Does your family use any traditional, folk, or ethnic remedies or cosmetics (such as Greta, Azarcon, Ghasard, Ba-baw-san, Sindoor or Kohl)?
- ☐ **My child has none of the above**