



12 Month Health Maintenance Questionnaire

Patient Name _____

Who accompanied child today?
(name and relationship to child) _____

Who does child live with? _____

Any Chronic health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Feedings:

What type of milk is your baby getting? _____

Method of milk feeding? Cup Breast Bottle

Using mostly table food or baby foods? _____

Finger Feeding some foods? Yes No

Does your child or any household member
drink water from a private well? Yes No
(consider vacation homes, relative's or
friend's homes, daycare or school)

Any concerns with stooling or urination? _____

If you do not understand any of these questions, please ask your nurse.

Sleep pattern:

Average hours of nighttime sleep: _____

Number of naps: _____

Length of naps: _____

Where does your child sleep? _____

Please list current medications: _____

Any allergies to medicine? _____

Does your baby:

Bang 2 cubes held in hand? Yes No

Pull to stand and walk or take steps w/ support? Yes No

Stand alone? Yes No

Place objects inside of other objects? Yes No

Wave bye-bye? Yes No

Imitate vocalizations and sounds? Yes No

Speak one or two words? Yes No

Jabber with inflections of normal speech? Yes No

Follow simple directions? Yes No

Imitate activities? **combing hair, doing housework, brushing teeth?** Yes No

Does your child point to things to get you to look? Yes No

Tuberculosis Screening Questionnaire:

Does your child have contact with adults with TB infection?
Yes No

Is child or parent are from region of world with high prevalence of TB?
Yes No

Is child frequently exposed to immunosuppressed persons, homeless people, nursing home residents, or migrant workers?
Yes No

Does either parent or other individual living in home work in a medically related field or have contact with institutionalized individuals or nursing home residents?
Yes No

If you do not understand any of these questions, please ask your nurse.