12 MONTH QUESTIONNAIRE

Name of Patient________________________DOB_________________

1. Feeding History
   a. ☐ Formula(name):____________How much?_____oz every____hours.
   b. ☐ Whole milk ☐ 2%milk ☐ 1%milk ☐ Other________________
      How much?________oz every ________hours
   c. ☐ Breastmilk_____minutes on each side, every_____hours.
   d. ☐ Bottle ☐ Sippy Cup ☐ Both
   e. Juice: ☐ Diluted ☐ Undiluted ☐ How much?_____ oz per day.
   f. Solid Food: (please circle) Cereal, Vegetable, Fruit , Meat, Finger Foods,
      Other____
2. Stools ☐ Soft ☐ Hard
3. Has your baby been in contact with anybody who has active Tuberculosis ☐ Y ☐ N
4. Has your baby seen a dentist? ☐ Y ☐ N
   Dentist's Name:_____________________ Last Appointment_________________

Development:

1. Crawls ☐ Y ☐ N
2. Pulls to standing ☐ Y ☐ N
3. Walks with support ☐ Y ☐ N
4. Feeds Self ☐ Y ☐ N
5. Pincer Grasp ☐ Y ☐ N
6. Peekaboo ☐ Y ☐ N
7. Looks at pictures ☐ Y ☐ N
8. Uses 2 words ☐ Y ☐ N
9. Points to eyes and ears ☐ Y ☐ N
10. Patty-cake sounds ☐ Y ☐ N
11. Waves bye bye ☐ Y ☐ N

Other Comments/Concerns-
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