![wasatch pediatrics | ST. MARK'S]

PT ID: _____ Patient's Name: _____

PCP: _____ Date of Birth: _____

Today's Date: _____

12 Month Old Parent Observations

Are there any concerns you would like to discuss today? _____

_____

Feedings:

Any concerns about feedings or weight gain? ………………………………………………………… YES   NO

Does your child eat well (i.e. has consistent appetite, not took picky)? ………………………….. YES   NO

Fluids: ☐ Breastfeeding   ☐ Formula   ☐ Whole Milk   ☐ Juice   ☐ Other: _____

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) …………………………….. YES   NO

Quality of stools: ☐ Liquidy/Seedy   ☐ Soft/Formed   ☐ Hard pellets/Logs

Any concerns about sleep? …………………………………………………………………………………YES   NO

How many uninterrupted hours of sleep at night (i.e. in between feeds)? _____

How many naps per day? _____   How long is each nap? _____

Development:

Are you reading to your child? ……………………………………………………………………………. YES   NO

Does your child watch TV/tablet/phone/have other screen time? ………………………………… YES   NO

        (If yes, how much screen time per day? _____)

Do you have any concerns about your child's hearing or vision? …………………………………YES   NO

Any concerns about your child's development? ………………………………………………………YES   NO

Does your child: (check all that apply)

☐ cruise	☐ use 1-2 words	☐ claps
☐ stand but no steps	☐ imitate activities	☐ points
☐ walk with support	☐ help getting dressed	☐ waves

Social/Behavior:

If parent(s) work, who cares for your child? _____

Are there any family or social issues you would like to discuss? …………………………………..YES   NO

Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? ………………………. YES   NO

Is discipline (such as teaching, setting limits) a problem? ……………………………………………. YES   NO

Safety/Preventative Health:

Do you brush your child's teeth?   ☐ YES   ☐ NO   If yes, using fluoride toothpaste?   ☐ YES   ☐ NO

Is your home "child-proofed"? ……………………………………………………………………………. YES   NO

Is your home/car a smoke-free environment? ……………………………………………………….. YES   NO

Does your child use a rear-facing car seat 100% of the time? ……………………………………. YES   NO

** A child should be rear-facing as long as possible, until they reach the highest weight or height allowed by their seat**

Do you have any questions/concerns about vaccines? …………………………………………………. YES   NO

Any recent illnesses or fevers in the last 24 hours? ……………………………………………………. YES   NO

Does your child have any allergies (that you know of)? ……………………………………………… YES   NO

Please list any medications or supplements you child took this week: _____

_____