Patient ID__________________ Patients Name____________________

PCP______________________ DOB_____________________________

Today's Date_______________

12 Month Old Parent Observations

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

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Feedings/Sleep:

Any concerns about feedings or weight gain?	Yes	No
Does your child eat well (i.e. has consistent appetite, not too 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
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: (please 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:

If parents 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

Utah Law: A child should be rear-facing until age 2 years & 30 lbs

Do you have any questions/concerns about immunizations?	Yes	No
Any illness 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 your child took this week: ______________________

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