Boulevard Center Pediatrics, Inc.

"Where your children are the center of our attention."

Well Visit Questionnaire (10 Months of Age –24 Months of Age)

Patient Name: **Date of Birth:**

Date of Visit: **Parent/Caregiver Name of Person Completing Form:**

General Information:

1. Does your child currently have any medical problems/illness? □ YES □ NO
   If YES, please explain:

2. Does your child have any allergies? □ YES □ NO
   If YES, please explain:

3. Does your child take any medication? □ YES □ NO
   If YES, please explain:

4. Does your child take any vitamins (Ex. D-Vi-Sol): □ YES □ NO
   If YES, please explain:

5. Did your child visit the Emergency Room this year? □ YES □ NO
   If YES, please explain:

6. Did your child have any major injury or fracture in the past? □ YES □ NO
   If YES, please explain:

7. Did your child stay in the hospital for more than 1 day in the past? □ YES □ NO
   If YES, please explain:

8. Has your child had any surgery in the past? □ YES □ NO
   If YES, please explain:

Feeding

1. Please indicate how your child is fed: □Breast Fed □Bottle Fed □Regular Milk □Other Milk_____
2. How often is your child feeding? # of Ounces (Ozs) _____ Every _____hours
3. If using formula, please indicate which one you are using: □Similac Advance □Similac Sensitive □Alimentum □Enfamil Infant □Enfamil Sensitive □Gentlease □Soy □Nutramingen □Other (Please Name)
4. If taking baby food, please indicate what your child is using: □Cereals □Baby Food Stage 1 □Baby Food Stage 2 □Table Food □Eggs/Chicken □Seafood □Peanut Butter/Powder □Other (Explain)

_____

Elimination

1. Does your child have a bowel movement every day? □ YES □ NO
2. Is your child's bowel movement □Soft □Hard

Tuberculosis Screening (If YES for any question below, please ask for TB test.)

1. Have you been abroad for more than 1 month in the past 5 years (outside of the US & Canada?) □ YES □ NO
2. Do you have a close contact of a person known to have TB? □ YES □ NO
3. Do you have a close contact of a person suspected to have TB (HIV+, Drug User or Prison Inmate?) □ YES □ NO

Lead Risk Screening (If YES for any question below, please ask for a lead test.)

1. Do you live in or regularly visit a house built before the 1950s? □ YES □ NO
2. Do you live in or regularly visit a house built before 1978 that has recently been renovated? □ YES □ NO
3. Do you have a sibling or playmate who has or did have lead poisoning? □ YES □ NO

Please turn page over for additional questions.

Sleep:
1. Does your baby have a regular sleep schedule? □ YES □ NO
2. Does your baby sleep on a safe surface (firm mattress, no pillows or other items in crib/bassinet?) □ YES □ NO

Social History:
Do you live with □Both Parents □Mom Only □Dad Only □Grandparents □Other _____

Mom Birth Year_____ Dad Birth Year_____

Any Smokers in the home? □ YES □ NO
Any Pets in the home? □ YES □ NO
Do you attend Daycare? □ YES □ NO

Family History (Please Check "√" where applicable)

Relation	Alive (A) or Deceased (D)	Asthma	Allergies	Diabetes	High Cholesterol	High Blood Pressure	Thyroid	Migraine	Other
Mother	□A □D								
Father	□A □D								
Siblings	How many Brothers? How many Sisters?								
Paternal Grandfather	□A □D								
Paternal Grandmother	□A □D								
Maternal Grandfather	□A □D								
Maternal Grandmother	□A □D								

Parent/Guardian Signature:_____

Administered/Reviewed By_____ Date:_____