Patient Name_____DOB_____

12 Months Review of Systems

Do you brush your child's teeth 2 times per day	Yes	No	Comment
Primary water source contains fluoride	Yes	No	Comment
Does your child stand alone?	Yes	No	Comment
Bangs toys together?	Yes	No	Comment
Drinks from a cup or sippy cup?	Yes	No	Comment
Speaks 1 to 2 words	Yes	No	Comment
Babbles	Yes	No	Comment
Tries to make same sounds you do	Yes	No	Comment
Waves bye-bye	Yes	No	Comment
Plays peek-a-boo	Yes	No	Comment
Looks at things you are looking at	Yes	No	Comment
Cries when you leave	Yes	No	Comment
Hands you a book to read	Yes	No	Comment
Follows simple directions	Yes	No	Comment
Concerns about how child sees	No	Yes	Concerns
Concerns about how child hears	No	Yes	Concerns
Any concerns for crossing, drifting, or lazy eyes	No	Yes	Comment

Hip dyplasia risk:

Was baby breech in the last month of pregnancy?	No	Yes	Unknown	Comment
Was your child a multiple (twin, triplet, etc?)	No	Yes	Unknown	Comment
Is there a family history of hip dysplasia?	No	Yes	Unknown	Comment
Does your child have any neurological abnormalities (cerebral palsy, down syndrome, etc?)	No	Yes	Unknown	Comment

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Lead risk:

Have any members of the family or your child's playmates had high blood lead level	No	Yes	Unknown	Comment
Does child live/visit house built before 1978 currently being renovated	No	Yes	Unknown	Comment
Does child live/visit a house/apartment building built before 1950	No	Yes	Unknown	Comment

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TB risk:

Born in country outside of the United States	No	Yes	Unknown	Comment
Traveled or had contact with high TB risk populations longer than a week	No	Yes	Unknown	Comment
Family member or contact had tuberculosis or positive TB skin test	No	Yes	Unknown	Comment
Is the child HIV Positive	No	Yes	Unknown	Comment

Anticipatory Guidance:

Has a regular bed time routine	Yes	No	Comment	
Plays actively for an hour or more per day	Yes	No	Comment	
Hours per day child watches TV	None	Less than 2	How many Hrs_____	
Parent is aware peanuts, popcorn, hotdogs, raw carrots are choking hazards	Yes	No	Comment	
Child tries to feed self using spoon or fork	Yes	No	Comment	
Regular car seat use	Yes	No	Comment	
Household cleaners, chemicals and medications are locked up	Yes	No	Comment	
Crib is on lowest setting	Yes	No	Comment	
Always stay in arms reach when bathing Even if using a bath seat	Yes	No	Comment	
Swimming pool, pond, or lake near home	No	Yes	Comment	
Does anyone smoke around child	No	Yes	Comment	