Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

12 Month Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have concerns about any of the following for your child? …….. Y N
   Vision Hearing Eating Sleeping
2. Does your child take a bottle to bed? ..... Y N
3. Do you have any questions about rules/discipline? ..... Y N
4. Has your child had any injuries since last visit? ..... Y N

SAFETY

5. Do you always use a car seat positioned in the back seat? ..... Y N
6. Do you avoid foods that can cause your child to choke? ..... Y N
   (hot dogs, peanuts, popcorn, raw carrots, hard candy)
7. Does your child spend time with anyone that smokes? ..... Y N
8. Is there a gun in your home? ..... Y N
   If yes, is it locked? ..... Y N
9 Do you have pets in your home? ..... Y N
10. Do you put sunscreen on your child?..... Y N
11. Are cleaning supplies and medications stored out of reach or locked? ..... Y N
12. Do you have the poison control phone number (1-800-222-1222)?..... Y N
13. Do you have smoke alarms and carbon monoxide detectors in your home? ..... Y N
14. Do you have any concerns regarding the use of alcohol or drugs by
    Anyone caring for your child? ..... Y N
15. Do you have any concerns regarding violence in your home?..... Y N

SOCIAL

16. Do you have someone you can talk to when you are stressed? ..... Y N
17. Do you have any support or help in caring for your child?..... Y N
18. Are there any new stresses or recent changes impacting your family
    (job change, move, divorce, illness)? ..... Y N

FAMILY MEDICAL HISTORY

19. In the past year has anyone in your child's extended family been diagnosed with a
    chronic illness (such as heart disease or diabetes)? ..... Y N

Parent / Guardian Signature and Date	Provider Signature and Date

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LEAD RISK

20. Do you have reason to believe that your child may have blood lead poisoning? ..... Y N
21. Has your child moved to Ohio from a foreign country or from a major metropolitan area within the last 12 months? ..... Y N
22. Does your child live within the city limits of Columbus? (not the suburbs) ..... Y N
23. Do you receive Medical Assistance (MA) which includes Prepaid Medical Assistance Program (PMAP)? ..... Y N
24. Will your child be attending Headstart? ..... Y N
25. During the past six months, has your child lived in or regularly visited a home, childcare, or other building built before 1978 with recent or ongoing repair, remodeling or damage (such as water damage or chipped paint)? ..... Y N
26. During the past six months, has your child lived in or regularly visited a home, childcare or other building built before 1950? ..... Y N
27. Has your child's brother, sister, housemate or playmate been diagnosed with blood lead poisoning? ..... Y N

TB RISK

28. Does your child live with, or have contact with (more than once a week) an adult with known tuberculosis? ..... Y N
29. Has your child tested positive for the AIDS virus? ..... Y N
30. Is your child exposed on a regular basis (more than twice a week) to anyone infected with AIDS; homeless; in a nursing home, prison or group home; or IV drug user? Y N
31. Is your child living in a home with foster children or is he/she a foster child? ..... Y N
32. In the past 5 years have you, your child or anyone your child lives with moved or been adopted from anywhere in Asia, Middle East, Africa or Latin America? ..... Y N
33. Does your child have any of the following chronic medical problems: Diabetes, Renal (kidney) failure, or Malnutrition? ..... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date