12 Month Well Check Questionnaire

Do you have any questions or concerns that you would like to discuss with your doctor? ....

If yes, please describe: .................................................................

☐ Yes  ☐ No

NUTRITION
1. What does your child eat? Check all that apply:  ☐ Breast milk  ☐ Formula  ☐ Cow's milk  ☐ Solid foods

☐ No  ☐ Yes

2. Have you started weaning your child from the bottle? .................................................................

☐ No  ☐ Yes

3. Do you offer your child fruits or vegetables with most meals and snacks? .................................................................

☐ Yes  ☐ No

4. Does your child drink juice? .................................................................

☐ Yes  ☐ No

DENTAL HEALTH
5. Do you give your child a bottle with anything in it except formula, milk, or water? .................................................................

☐ Yes  ☐ No

6. Has your child seen a dentist? .................................................................

☐ Yes  ☐ No

TUBERCULOSIS
7. Has your child had close contact with anyone who has tuberculosis (TB) or who has had a positive TB skin test? .................................................................

☐ Yes  ☐ No

8. Was your child born in a country at high risk for tuberculosis (including countries in South America, Central America, Africa, Asia [except Japan], Eastern Europe, Russia, and surrounding areas), or has anyone in your household (including your child) traveled to one of these countries? .................................................................

☐ Yes  ☐ No

SAFETY
9. Do you give your child foods that may cause choking (such as hot dogs, nuts or seeds, whole grapes, and hard or sticky candy)? .................................................................

☐ Yes  ☐ No

10. Do you place your child in a rear-facing car seat in the backseat for every car ride? .................................................................

☐ Yes  ☐ No

11. If your home has more than one floor, do you have safety guards on the windows and gates on the stairs? .................................................................

☐ Yes  ☐ No

12. Do you know what to do if your child is choking? .................................................................

☐ Yes  ☐ No

13. Does your home keep cleaning supplies, medicines, and matches locked away? .................................................................

☐ Yes  ☐ No

14. Do you stay with your child at all times around water (such as in the bathtub and around pools, ponds, and buckets)? .................................................................

☐ Yes  ☐ No

15. Does your child live in, or spend a lot of time in, a building that was built before 1978 and has peeling or chipped paint, or that has been recently renovated? .................................................................

☐ Yes  ☐ No

YOUR GROWING CHILD
16. Does your child play games like “peekaboo” or “patty-cake”? .................................................................

☐ Not yet  ☐ Somewhat  ☐ Yes, often

17. Does your child call you “mama” or “dada” or similar name? .................................................................

☐ Not yet  ☐ Somewhat  ☐ Yes, often

18. Does your child look around when you say things like, “Where’s your bottle?” or “Where’s your blanket?” .................................................................

☐ Not yet  ☐ Somewhat  ☐ Yes, often

FAMILY LIFE
19. Does your child watch TV or movies, or play games on a phone or tablet? .................................................................

☐ Yes  ☐ No

20. Since your child’s last check-up, has your family or child experienced any major issues (such as illness, move, job change or loss, separation or divorce, death in the family)? .................................................................

If yes, please list: .................................................................

☐ Yes  ☐ No

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12個月
健康核查問卷

請回答以下有關您孩子的問題。
請跳過任何您無法回答或不適用的問題。
您的回答將幫助我們為您和孩子提供最佳護理。

您有任何疑問或顧慮想要諮詢醫生嗎？

如果回答「是」，請說明：

營養
1. 您給孩子吃什麼？勾選所有適用選項：
   - [ ] 母乳
   - [ ] 奶粉
   - [ ] 牛奶
   - [ ] 固體食物

2. 您開始讓孩子斷奶瓶了嗎？
   - [ ] 否
   - [ ] 是

3. 您是否在大部分正餐和點心中都會給孩子水果或蔬菜？
   - [ ] 否
   - [ ] 是

4. 您的孩子喝果汁嗎？
   - [ ] 是
   - [ ] 否

牙齒健康
5. 除裝有沖泡奶粉、牛奶或水的奶瓶外，您還會給孩子裝有其他東西的奶瓶嗎？
   - [ ] 否
   - [ ] 是

6. 您的孩子看過牙醫嗎？
   - [ ] 否
   - [ ] 是

結核病
7. 您的孩子曾經和任何結核病 (TB) 患者或結核病皮膚測試呈陽性的人有過近距離接觸嗎？
   - [ ] 否
   - [ ] 是

8. 您的孩子是否出生在結核病高風險國家 (包括中南美洲、非洲、亞洲 [日本除外]、東歐國家、俄羅斯及周邊地區)，或者您家裡是否有人（包括您的孩子）曾到過這些國家或地區？
   - [ ] 否
   - [ ] 是

安全
9. 您會給孩子吃可能導致哽噎的食物（例如熱狗、堅果或種籽、整顆葡萄、硬糖或軟糖）嗎？
   - [ ] 否
   - [ ] 是

10. 您每次開車帶孩子出門時，是否讓孩子坐在後座的兒童安全座椅上，面朝後方？
    - [ ] 否
    - [ ] 是

11. 如果您家不只一層樓，那麼窗戶是否有安全鎖，樓梯是否有柵門？
    - [ ] 否
    - [ ] 是

12. 您知道萬一孩子哽噎該怎麼辦嗎？
    - [ ] 否
    - [ ] 是

13. 您家裡的清潔用品、藥品和火柴是否都已收好並上鎖？
    - [ ] 否
    - [ ] 是

14. 當您的孩子靠近水邊時（例如浴缸裡或泳池、池塘或水桶邊），您是否一直在旁看護？
    - [ ] 否
    - [ ] 是

15. 您的孩子是否居住或長時間待在1978年以前修建，且油漆剝落或碎裂，或是剛裝修好的房子里？
    - [ ] 否
    - [ ] 是

成長中的孩子
16. 您的孩子玩「躲貓貓 (peekaboo)」或「金蘋果 (patty-cake)」之類的遊戲嗎？
    - [ ] 還不會
    - [ ] 稍微
    - [ ] 是，經常

17. 您的孩子叫您「麻麻 (mama)」或「噠噠 (dada)」或類似稱呼嗎？
    - [ ] 還不會
    - [ ] 稍微
    - [ ] 是，經常

18. 當您說「你的奶瓶在哪裡」或「你的毯子在哪裡」時，您的孩子會左顧右盼嗎？
    - [ ] 還不會
    - [ ] 稍微
    - [ ] 是，經常

家庭生活
19. 您的孩子會看電視或影片，或者玩手機或平板電腦上的遊戲嗎？
    - [ ] 否
    - [ ] 是

20. 從孩子上一次檢查至今，您的家人或孩子是否經歷任何重大變故（例如生病、搬家、換工作或失業、分居或離婚、家人去世）？
    - [ ] 否
    - [ ] 是

如果回答「是」，請列示：

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