Please answer the following questions and hand this form to the clinical assistant. Your answers will help your doctor choose the best topics to discuss with you during your visit today. Skip any questions that you don’t understand or that do not apply. This information is confidential.

What would you like to discuss with your doctor today?

1. Since your last visit, have there been any MAJOR illnesses, hospitalizations, changes or stresses for your family or child? □ Yes □ No
2. Is your child taking a vitamin supplement? □ No □ Yes
3. Has your child ever had a reaction to a vaccine (such as a high fever)? □ Yes □ No
4. Is your child still on a bottle? □ Yes □ No
5. Does your child drink or eat food prepared with tap water (from a city source)? □ No □ Yes
6. Do you avoid feeding your child foods that he or she may choke on (nuts, hard or jelly candies, popcorn, raw vegetables, or hot dogs)? □ No □ Yes
7. Do you limit crackers, sweets, and juice (less than 6 ounces per day)? □ No □ Yes
8. Do you have any concerns with your child’s bowel movements or urination? □ Yes □ No
9. Do you brush your child’s teeth with water or training toothpaste every day? □ No □ Yes
10. Can your child hear and see well? □ No □ Yes
11. Is there a TV in your child’s bedroom? □ Yes □ No
12. Do you do play and read with your child every day? □ No □ Yes
13. Do you have any concerns about tantrums or disciplining your child? □ Yes □ No

SAFETY

14. Do you watch your child at all times when playing near a street or driveway? □ No □ Yes
15. Do you watch your child at all times around water (pool, ocean, or tub)? □ No □ Yes
16. Do you place your baby in a car seat facing backwards, in the back seat? □ No □ Yes
17. Do you keep all medications, house cleaning products, and poisons in a cabinet out of reach? □ No □ Yes
18. Do you have the poison control center number available? □ No □ Yes
19. If you have stairs in your home, have you placed a safety gate at the top and bottom? (If there are no inside stairs inside, check here □ ). □ No □ Yes
20. Do you put sunscreen on your child when he or she is outside for more than 20 minutes? □ No □ Yes

DEVELOPMENT

21. [CHAT] Does your child make good eye contact? □ No □ Yes
22. [CHAT] Is your child interested in other children / siblings? □ No □ Yes
23. [CHAT] Will your child pay attention and follow a pointed finger? □ No □ Yes
24. [CHAT] Does your child respond to his or her name? □ No □ Yes
25. [CHAT] Does your child play “peek-a-boo” or other interactive games? □ No □ Yes
26. [CHAT] Does your child bring you objects for show? □ No □ Yes
27. [CHAT] Does your child show affection by hugging or kissing you? □ No □ Yes
28. Does your child run? □ No □ Yes
29. Does your child follow simple directions? □ No □ Yes
30. Can your child use utensils? □ No □ Yes
31. Can your child say four to six words? □ No □ Yes
32. Can your child point to one body part when asked? □ No □ Yes
Directions
- If you have not completed the following questionnaire for Kaiser Permanente on behalf of your child, please complete the survey below.
- If you have completed this survey on behalf of your child during a previous visit, you do not need to fill this out again.

### Lead Screening

1. Does your child have a sibling or playmate who has or had lead poisoning?  
   - Yes  
   - No

2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently (within the past 6 months) been renovated or remodeled?  
   - Yes  
   - No

3. Does your child live in or regularly visit a house or child care facility built before 1950?  
   - Yes  
   - No

### Tuberculosis Screening

1. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?  
   - Yes  
   - No

2. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?  
   - Yes  
   - No

3. Has a family member or contact had tuberculosis or a positive tuberculin skin test?  
   - Yes  
   - No

4. Is your child infected with HIV or exposed to someone who is infected with HIV?  
   - Yes  
   - No