



Pre-Visit Questionnaire 12 month Visit

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today? _____

Questions about your child.

Have any of your child's relatives developed new medical problems since your last visit?
 Yes No Unsure If yes, please explain: _____

Hearing	Do you have any concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have any concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold objects close when trying to focus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is there a family history of strabismus (eye crossing or lazy eye)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
* LEAD	Does your child have a sibling or playmate that has had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
* Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries <u>other</u> than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Have there been any major changes in your family lately? No Yes

Move Separation Divorce Death in the family Job change Other _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things Not at all Several Days More than half the days Nearly every day

2. Feeling down, depressed, or hopeless Not at all Several Days More than half the days Nearly every day

* Does your child live with anyone who uses tobacco or spend time in any place where people smoke? Yes No

Does your child have any special health care needs? Yes No If yes, please explain: _____

* List your child's current medications and doses: Include any herbs, vitamins or supplements: _____

* What is the best way to contact you (please circle): home phone / cell phone / work phone: _____

* Would you like to share your email address? _____