

Patient Name/Date of Birth: \_\_\_\_\_

## Well Baby Check: 15 month visit questionnaire

**Interval History:**

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office?	No	Yes
Has your child had any reactions to vaccinations in the past?	No	Yes

**Development:**

Can your child scribble with a crayon/pencil?	Yes	No	
Can your child drink from a cup?	Yes	No	
Does your child feed him/herself finger foods?	Yes	No	
Does your child say at least 3 words (e.g. "Hi", "No", "Uh-oh")?	Yes	No	
Does your child say "words" that you don't understand (jargoning)?	Yes	No	
Does your child understand and follow simple commands?	Yes	No	
Can your child walk alone?	Yes	No	
Can he or she bend (stoop) to pick something up and stand up again?	Yes	No	
Can your child crawl up stairs?	Yes	No	N/A
Can your child stack two blocks or objects (one on the other)?	Yes	No	
Do you read to your child regularly?	Yes	No	
Do you have concerns about how your child hears or speaks?	No	Yes	
Do you have any concerns about how your child sees?	No	Yes	
Does your child hold objects close when trying to focus?	No	Yes	
Do your child's eyes appear unusual or seem to cross, drift or be lazy?	No	Yes	
Do your child's eyelids droop or does one eyelid tend to close?	No	Yes	

**Dental Health:**

Do you help your child brush and floss his/her teeth daily?	Yes	No	
Does your child's primary water source contain fluoride?	Yes	No	Unsure
If no, does your child take a fluoride supplement?	Yes	No	N/A
Do you know a dentist to whom you can bring your child?	Yes	No	

**Staying Healthy/Safety/Tobacco Exposure:**

Does your child watch TV, play video games, or use a smart phone or tablet?	No	Yes	
Does your home have a working smoke detector?	Yes	No	
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A



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- Is your child eating fruits and vegetables at least two times per day?      Yes    No
- Does your baby drink or eat 3 servings of calcium-rich foods daily,  
 such as milk, soy milk, cheese, yogurt, or tofu?      Yes    No
- Does your child eat high fat foods such as fried foods, chips,  
 ice cream or pizza more than once per week?      No    Yes
- Does your child drink soda, sports drinks, energy drinks or  
 other sweetened drinks?      No    Yes
- Does your child eat meat (such as chicken, fish, beef or pork)?      Yes    No
- Does your child play actively most days of the week?      Yes    No
- Do you have any concerns about your child's weight or feeding?      No    Yes

**Elimination:**

- Does your child have bowel movements on a regular basis with  
 a normal (soft) consistency?      Yes    No

Please list any medications or supplements your child is taking: \_\_\_\_\_

Who lives in the home with your child? \_\_\_\_\_

Who provides daytime care for your child? \_\_\_\_\_

Please list any new major family medical issues: \_\_\_\_\_

 Please list any known allergies to medicines: \_\_\_\_\_

 Please list any known food allergies: \_\_\_\_\_

 Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?  
 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b><i>Clinic Use Only</i></b>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><input type="checkbox"/> Patient Declined the SHA</b>
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name:		Date:	