Patient Name:

Date of Birth:

Well Baby Check: 15 month visit questionnaire

Interval History:

Has your child had any major illnesses or doctor visits since last seen here?	No	Yes
Has your child had any reactions to vaccinations in the past?	No	Yes

Development: Can your child (check all that apply) –

_ scribble with a crayon/pencil?
_ drink from a cup and feed him/herself finger foods?
_ say at least 3 words (eg. "hi", "no", "uh-oh")
_ say "words" that you don't understand (jargoning)?
_ understand and follow simple commands?
_ walk alone?
_ bend down and then stand up again?
_ crawl up stairs?
_ stack 2 blocks or objects (one on another)?
_ enjoy books?

Who provides daytime care for your child? ____

Nutrition/Elimination/Physical Activity:

How much milk does your child drink? _____ oz per day of [breast milk] [formula] [whole milk] [other ________ ___]

Does your baby get 3 servings of calcium-rich foods daily?	Yes	No
Is your child eating 4 servings per day of a variety of fruits and vegetables?	Yes	No
Does your child eat iron-rich foods (meat, iron fortified cereal, beans) daily?	Yes	No
How much juice or other sweet beverage does your child drink per day?	____ oz	
Does your child eat junk food or fast food more than twice per week?	No	Yes
Are there any problems with pooping or peeing?	No	Yes
Does your child play actively most days of the week?	Yes	No

Baby's medications/vitamins/supplements: ____

Dental Health:

Do you help your child brush teeth daily?	Yes	No
Does your child use a pacifier?	No	Yes
Does your child drink from a bottle?	No	Yes

Sleep:

How long does your child sleep at night without awakening?	____ hours	
How long does your child nap throughout the day?	_____ hours	
Does your child sleep through the night without feeding?	Yes	No
Can they self-soothe?	Yes	No

Where does your child sleep? ____

Staying Healthy/Safety/Tobacco Exposure:

Does your baby get any screen time?	No	Yes	
Does your home have a working smoke detector?	Yes	No	
Is your water temperature set to less than 120 degrees?	Yes	No	N/A
Is your baby always supervised when near water, including the bathtub?	Yes	No	
Have you child-proofed your home?	Yes	No	

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Do you have safety guards on upper floor windows and gates for the stairs?	Yes	No	N/A
Does your home have cleaning supplies/medicines/matches locked away?	Yes	No	
Is the Poison Control Center number (800-222-1222) posted by/in your phone?	Yes	No	
Does your child use sun protection when outdoors?	Yes	No	
Is your car seat appropriately sized, rear-facing, and in the back seat?	Yes	No	
Are all guns stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your baby spend time with anyone who smokes or vapes?	No	Yes	

Please list any new major family medical issues:

____

Who lives in the home with your child?

____

What international travel has your child had since their last well check? (where and how long)

____

What plans are there for international travel with your child in the next 12 months? (where and how long)

____

What concerns would you like to discuss today?

____