Patient Name:

Date of Birth:

Well Baby Check: 18 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? ___feed with a spoon?
_ say at least 4-10 words?
_ understand/follow simple commands?
_ walk well? ___run? ___climb?
_ point to 4-6 body parts when asked?
_ 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] [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, or beans) daily? Yes No
How much juice or sweet beverages does your child drink? ____ oz per day
Does your child eat junk/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
Your child's medications/vitamins/supplements: ____

Dental Health:

Do you help your child brush and floss 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
Can they self-soothe? Yes No
Where does your child sleep? ____

Staying Healthy/Safety:

Does your child 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 child always supervised when near water, including the bathtub? Yes No
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
Do you always check for children before backing your car out? Yes No
Does your child wear a helmet and sit in an approved bike seat when on a bike? Yes No N/A

Stanford Children's Health | Lucile Packard Children's Hospital Stanford
Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

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Questionnaire ● Well Baby Check 18 Month

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?

____

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L15682

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

Question		
1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee	Yes	No

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Child's Name: ______________________________ DOB: ______________

Completed by: ______________________________ Date completed: ______________