Medical Record Number

Patient Name

Patient Label

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	

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Staying Healthy/Safety/Tobacco Exposure:

Question			
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
If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	N/A
Does your home have cleaning supplies/medicines/matches locked away?	Yes	No	
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	
Do you always stay with your child when she/he is in the bathtub?	Yes	No	
Do you and your child spend time near water (pool, river or lake)?	No	Yes	
If so, is your child always safely supervised?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Do you always place your child in a rear-facing car seat in the back seat?	Yes	No	
Is your car seat the right one for the age and size of your child?	Yes	No	
Do you always check for children before backing your car out?	Yes	No	
Does your child spend time in a home where a gun is kept?	No	Yes	Skip
If so, are all guns safely 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?	No	Yes	

Risk Assessment for Lead Exposure:

Question		
Does your child participate in any publicly supported programs (Medi-Cal, CHDP, Healthy Families, WIC)?	No	Yes
Does your child live in or regularly visit a house or child care facility built before 1950?	No	Yes
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?	No	Yes
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes
Does your child take any imported remedies or supplements?	No	Yes

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Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? No Yes
This includes all countries ***other than*** the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate ***for one month or more***? (Countries other than those listed above) No Yes

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection? No Yes Unsure

Is your child immunosuppressed (currently or planned)? No Yes
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

Sleep:

How many hours does your child sleep at night? ____ hours

How many hours does your child nap throughout the day? ____ hours

Does your child sleep through the night without feeding? Yes No

Nutrition/ Physical Activity:

How much milk does your child drink? _____ oz per day. Type: [breast milk] [formula] [whole milk] [other _____]

How much juice does your child drink in 24 hours? ____ oz

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 junk foods such as chips, fries, ice cream or fast food more than twice 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

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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?

____

____

Parent or Guardian Signature: ____

Date: ____________________

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	**☐ Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

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