



Well Baby Check: 18 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 with a spoon? Yes No

Does your child say at least 4-10 words? Yes No

Does your child understand and follow simple commands? Yes No

Can your child walk well, run and climb? Yes No

Can your child point to 4-6 body parts when asked? Yes No

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

Does your child have a dentist? 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

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 child wear a helmet when riding a tricycle or anything else with wheels?	Yes	No	N/A
Does your child spend time with anyone who smokes?	No	Yes	

Risk Assessment for Lead Exposure:

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	

Tuberculosis Screening:

Was your child born in a country with an elevated TB rate? This includes all countries <i>other than</i> the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.	No	Yes	
Has your child visited or lived in a country with an elevated TB rate <i>for one month or more</i> ? (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

Nutrition/Physical Activity:

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

How much juice does your child drink? _____ oz per day

Does your child drink from a bottle or take a pacifier? No Yes

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 iron rich foods (such as meat, eggs, iron-fortified cereals or beans)? Yes No

Do you have trouble affording to buy food for your family? No Yes

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 regular, normal (soft) bowel movements? 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? _____

Parent or Guardian Signature: _____

Date: _____

<i>Clinic Use Only</i>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div style="border: 3px double black; padding: 5px; display: inline-block;"> <input type="checkbox"/> Patient Declined the SHA </div>
<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:	