15 Month Pre-Visit Questionnaire

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions.

CHILD'S NAME:____________________________________DATE OF BIRTH:_________________

YOUR NAME:______________________________________RELATIONSHIP:_________________

Do you have any concerns, questions or problems that you would like to discuss today? Please describe:____
____
____

Does your child have any allergies? YES/NO If yes, please list:_____________________________
Does your child take any medications? YES/NO If yes, please list:__________________________
Has your child seen any other healthcare providers? YES/NO If yes, please list:______________

Have there been any recent changes in your family? (check all that apply)

_____ Death _____ Divorce Other: _________________________
_____ Job Change _____ Move _________________________

FEEDING/NUTRITION

Is your child drinking whole milk? YES/NO If yes, how much in a day? ___________ounces
What else does your child eat?____
____

BEHAVIOR/SOCIAL

Review of systems	Never	Sometimes	All the time
Do you any concerns about your child's development or behavior?			
Does your child have trouble sleeping?			
Does your child have a hard time calming down?			
Risk Assessment			
Does your child live with or spend time with anyone who smokes?			
In the past year did you ever worry that your food would run out before you got money to buy more?			

DEVELOPMENTAL MILESTONES: Please put a check beside the things your child is able to do.

_____	Walks well	_____	Drinks from a sippy cup
_____	Tries to copy what you do	_____	Brings toys or books to show you
_____	Puts a block in a cup	_____	Listens to a story
_____	Follows simple commands	_____	Scribbles

What words can your child say?____
____