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? Yes No
Has your child had any reactions to vaccinations in the past? Yes No

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
### 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 baby spend time with anyone who smokes?  No  Yes

### Risk Assessment for Lead Exposure:

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
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
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: ________________________________

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☐ Patient Declined the SHA

PCP’s Signature | Print Name: | Date: ________________________________

Ver.12-12-17