18 Month Pre-Visit Questionnaire

Instructions: Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health

1.	Do you have any concerns about your child's health?	NO	YES
2.	Any problems with previous immunizations?	NO	YES

Feeding/Nutrition

3.	Is your child still breastfeeding?	NO	YES
4.	Is your child drinking milk or formula?	YES	NO
	a. Which type of milk or formula?		
	b. How many ounces per day?		
5.	Does your child have fruits or vegetables at every meal?	YES	NO
6.	Are you giving your child mostly whole grains?	YES	NO
7.	Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods daily?	NO	YES
8.	Are you avoiding choking hazard foods (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
9.	Does your child drink from a bottle?	NO	YES
10.	Does your child drink juice or other sweetened drinks?	NO	YES
11.	Are you giving any vitamins or supplements?	YES	NO

Oral Health

12.	Are cavities a problem for you or anyone in your family?	NO	YES
13.	Are you using a soft toothbrush or cloth to clean your child's teeth two times per day?	YES	NO
14.	Do you have a dentist for your child?	YES	NO
15.	Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

16.	Problems with bowel movements (pooping)?	NO	YES
17.	Questions about toilet training?	NO	YES

Activity/Exercise/Screen time

18.	Does your child watch TV?	NO	YES
19.	Do you play with and read to your child every day?	YES	NO

Sleep

20.	Does your child sleep through the night?	YES	NO
21.	Do you have a bedtime routine?	YES	NO
22.	Does your child fall asleep on his own, in his own bed?	YES	NO

Social Stressors

23.	Are you able to take some time for yourself?	YES	NO
24.	Any major changes or stresses in your family recently?	NO	YES
25.	Do you ever worry your family will go hungry?	NO	YES
26.	Do you have daycare concerns?	NO	YES

Behavior

27. Excessive tantrums?	NO	YES
28. Questions about discipline?	NO	YES
29. Do you praise your child when she is behaving well?	YES	NO

Development

30. Indicates wants by pointing, pulling, etc.?	YES	NO
31. Waves bye-bye?	YES	NO
32. Knows two body parts?	YES	NO
33. Uses a spoon and cup without spilling most of the time?	YES	NO
34. Stacks two small blocks?	YES	NO
35. Has a vocabulary of six words?	YES	NO
36. Understands and responds to simple requests?	YES	NO
37. Runs well?	YES	NO
38. Climbs up and down stairs by holding on?	YES	NO

Lead

39. Regularly spends time in a house built before 1978?	NO	YES
a. Any peeling or chipping paint?	NO	YES
b. Any recent, ongoing, or planned remodeling?	NO	YES
40. Has a sibling or playmate who has had lead poisoning?	NO	YES

Safety

41. Is the crib mattress at the lowest position?	YES	NO
42. Is your child exposed to anyone who smokes?	NO	YES
43. House has working smoke detectors and carbon monoxide detectors?	YES	NO
44. Do you have a fire escape plan?	YES	NO
45. Do you keep your child away from the stove?	YES	NO
46. Do you have a gate on your stairs?	YES	NO
47. Do you keep furniture away from windows or use window guards?	YES	NO
48. Do you keep plastic bags and balloons away from your child?	YES	NO
49. Child rides in a rear-facing safety seat, in the back seat?	YES	NO
50. Do you have the number for Poison Control?	YES	NO
51. Swimming pool, pond, or lake near your home?	NO	YES

Tuberculosis

52. Has a family member or contact had tuberculosis disease?	NO	YES
53. Has a family member had a positive TB skin test (PPD)?	NO	YES
54. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
55. Has your child traveled to a high-risk country for more than	NO	YES

Review of Systems

56. Any concerns about your child's hearing?	NO	YES
57. Any concerns about your child's vision?	NO	YES