15 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 breastfeeding still?	YES	NO
a. How often?		
4. Is your child taking formula or milk well?	YES	NO
a. How many ounces?		
b. Which type of formula or milk?		
5. Child has fruits or vegetables at every meal?	YES	NO
6. Giving your child mostly whole grains?	YES	NO
7. Avoiding choking foods (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
8. Does your child still drink from a bottle?	NO	YES
9. Does your child drink juice or other sweetened drinks?	NO	YES
10. Giving any vitamins or supplements?	YES	NO
Oral Health		
11. Are cavities a problem for you or anyone in your family?	NO	YES
12. Does your child sleep with a bottle?	NO	YES
13. Does your child breast or bottle-feed in the night?	NO	YES
14. Using a soft toothbrush or cloth to clean child's teeth two times per day?	YES	NO
15. Do you have a dentist for your child?	YES	NO
16. Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Elimination		
17. Problems with bowel movements (pooping)?	NO	YES
Activity/Exercise/Screen time		
18. Does your child watch TV?	NO	YES
19. Do you play with your child every day?	YES	NO
20. Do you read to your child every day?	YES	NO
Sleep		
21. Does your child sleep through the night?	YES	NO
22. Do you have a bedtime routine?	YES	NO
23. Does your child fall asleep on his own, in his own bed?	YES	NO
Social Stressors		
24. Are you able to take some time for yourself?	YES	NO
25. Any major changes or stresses in your family recently?	NO	YES
26. Does your partner ever hurt you or your children?	NO	YES

27. Do you ever worry your family will go hungry?	NO	YES
28. Do you have daycare concerns?	NO	YES

Behavior

29. Excessive tantrums?	NO	YES
30. Questions about discipline?	NO	YES
31. Do you praise your child when he/she is behaving well?	YES	NO

Development

32. Knows one body part?	YES	NO
33. Communicates wishes well?	YES	NO
34. Brings objects over to show you?	YES	NO
35. Jabbers a great deal?	YES	NO
36. Says four to five words clearly?	YES	NO
37. Understands and follows simple commands?	YES	NO
38. Walks well?	YES	NO
39. Scribbles?	YES	NO
40. Copies things you do?	YES	NO
41. Listens to a story?	YES	NO

Safety

42. Crib mattress at the lowest position?	YES	NO
43. Is child exposed to someone who smokes?	NO	YES
44. House has working smoke detectors and carbon monoxide detectors?	YES	NO
45. Do you keep plastic bags and balloons away from your baby?	YES	NO
46. Child rides in a rear-facing safety seat, in the back seat?	YES	NO
47. Household cleaners, other chemicals, and medicines locked up?	YES	NO
48. Do you apply sunscreen if child is in the sun for more than 10 minutes?	YES	NO
49. Swimming pool, pond, or lake near your home?	NO	YES

Tuberculosis

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

Review of Systems

54. Any concerns about your child's hearing?	NO	YES
55. Any concerns about your child's vision?	NO	YES