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 concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your child's hearing?	NO	YES
5	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

6	Is your child still breastfeeding?	NO	YES
7	Is your child drinking formula or milk well?	YES	NO
	a. Which kind of milk or formula?		
	b. How much milk per day?		
8	Does your child eat fruits or vegetables at every meal?	YES	NO
9	Do you feed your child mostly whole grains?	YES	NO
10	Does your family eat junk foods (chips, cookies, crackers, candy) and/or fast foods more than once or twice per week?	NO	YES
11	Does your child snack more than 2 times a day?	NO	YES
12	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
13	Does your child drink from a bottle?	NO	YES
14	Does your child drink juice or other sweetened drinks?	NO	YES
15	Do you give your child any vitamins or supplements?	NO	YES
16	Are you worried about your child's weight?	NO	YES

Oral Health

17 Are cavities a problem for you or anyone in your family?	NO	YES
18 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
19 Do you have a dentist for your child?	YES	NO
20 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
21 Does your child only drink milk at meals?	YES	NO

Elimination

22 Does your child have any problems with bowel movements (pooping)?	NO	YES

Activity / Exercise / Screen Time

23 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
24 Do you play with your child every day?	YES	NO
25 Do you read to your child every day?	YES	NO

Sleep

26 Does your child sleep through the night?	YES	NO
27 Do you have a bedtime routine?	YES	NO
28 Does your child fall asleep on his own, in his/her own bed?	YES	NO

Social Stressors

29 Do you feel you receive the support you need?	YES	NO	
30 Have there been any major changes or stresses in your family recently?	NO	YES	
31 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
32 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES

Behavior

33 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
34 Do you praise your child when he/she is behaving well?	YES	NO

Lead

35 Is your child regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
36 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

37 Is the crib mattress at the lowest position?	YES	NO	
38 Does anyone smoke or vape around your child?	NO	YES	
39 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
40 Do you keep plastic bags and latex balloons away from your child?	YES	NO	
41 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO	
42 Do you keep your child away from the stove?	YES	NO	
43 If there is a swimming pool, pond or lake near your home, is it secured so that your child cannot access it?	N/A	YES	NO
44 Do you have a fire escape plan?	YES	NO	
45 Do you keep furniture away from windows or use window guards?	YES	NO	
46 Do you have a gate on your stairs?	YES	NO	
47 Do you have the number for Poison Control?	YES	NO	