Well Child Check: 15 Month Visit

Your Child’s Name: __________________________________________________

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you.

Does your child walk? Yes No Unsure
Does your child run? Yes No Unsure
Can your child feed himself with a spoon? Yes No Unsure
Does your child do pretend play (such as pretend to talk on the phone)? Yes No Unsure
Does your child play games with you? Yes No Unsure
Can your child point to some parts of his body when asked? Yes No Unsure
Can your child use at least 4 words? Yes No Unsure
Is your child completely weaned from the bottle? Yes No Unsure
Does your child usually drink more than 4 oz. of juice or sweetened drinks daily? No Yes Unsure
Is your baby getting breast milk or other milk? Breast milk Formula Other
How much breast milk, formula or other milk does your child drink in 24 hours? ______ oz. ______ Feeds
Does your child sleep through the night, without feeding? Yes No Unsure
Do you read to your child regularly? Yes No Unsure
Is your house child proofed? Yes No Unsure
Do you usually protect your child with sunscreen/hats/other measures when outdoors? Yes No Unsure
Do you have the poison control number (800 222-1222) posted at home? Yes No Unsure
Who provides daytime care for your child? _______________________________________________________
Does your water contain fluoride? Yes No Unsure
Is your child on any medications or supplements, including vitamins? If so, please list below:
_________________________________________________________________________________________

_________________________________________________________________________________________

Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds? No Yes Unsure
Do you have any international travel plans prior to your child’s second birthday, if so, when and where?
_______________________________________________________________________________________

Do you have any concerns about your child’s development, or any other concerns you would like to discuss with your provider?
If so, please describe:
_________________________________________________________________________________________
_________________________________________________________________________________________

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