15 - Month Well Check Questionnaire

Name _____

DOB _____

Chief Complaint Please circle or print appropriate answer

Do you have any concerns about your child?

Yes No

If so, explain _____

Does your child have any special health care needs?

Yes No

If so, explain _____

Has your child seen another doctor, been to the hospital, emergency room or urgent care since your last visit?

Yes No

If so, explain _____

Has your child had any procedures or tests done since their last visit?

Yes No

If so, explain _____

How many people are living in this child's home? _____

Including: Mother Father Sibling(s) Maternal Grandparent(s)

Paternal Grandparent(s) Other Family Member(s) Friend(s)

Significant other of Mother Significant other of Father

If this child is not living with both biological parents, what is the living situation?

Single custody Joint custody Family Member Foster Home

Adoptive home Other

If other, explain _____

Who takes care of your child during the day?

Family Member Parent Babysitter/Nanny Daycare

How many hours a day is your child in someone else's care? _____

Have there been any major changes for your child or in your family lately?

Yes No

What kind of change?

Separation Divorce Change in caregiver Move

Return to work/school Job change Loss of job

Money problems Significant illness Death in the Family Other

Does your child live with anyone who smokes or spend time in any places where people smoke? Does anyone smoke in the car your child travels in?

Yes No

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Review of Systems Please circle or print appropriate answer

If your child drinks formula or milk, how may ounces do they drink per day? _____

What kind of milk or formula does your child drink?

Cow Soy Rice Almond Enfamil Similac Good Start Generic brand Other milk source

If your child is breastfeeding, how many minutes does your child breastfeed for per feeding? _____

How many feedings does your child have per day? _____

How many ounces of water does your child drink per day? _____

Where does your child's drinking water come from?

Tap Well Bottled

How many ounces of juice does your child drink per day? _____

Does your child use a bottle or a cup?

Bottle Cup

Is your child eating solid foods like baby cereals and baby foods?

Yes No

What types of solid foods is your child eating?

Fruits Vegetables Grains Dairy Protein Junk food

Fast food

Is your child feeding him/herself?

Yes More than 50% of the time Less than 50% of the time No

Does your child try and taste new foods?

Yes No

How often do you have meals together as a family?

Once per day 4-6 times per week 3-5 times per week

1-2 times per week Occasionally Rarely Never

Does your child have any problems with eating?

Yes No

If so, describe _____

Does your child take vitamins or supplements?

Yes No

If so, describe _____

Do you have concerns regarding your child's urination or peeing?

Yes No

If so, describe _____

Do you have concerns regarding your child's bowel movements or poop?

Yes No

If so, describe _____

Does your child's diaper stay dry for 2 or more hours?

Yes No

Does your child know when their diaper is wet or dry?

Yes No

Does your child tell you when they have a need to go poop or have a bowel movement?

Yes No

Can your child pull their own pants up and down?

Yes No

How many hours does your child sleep at night? _____

How many naps does your child take per day? _____

How long does your child nap for? _____

Does your child have problems with sleeping?

If so, describe _____

How often are your child's teeth brushed?
Once per day Twice per day Does not brush teeth

How often are your child's teeth flossed?

Once per day Twice per day Does not floss

How often does your child see the dentist?

Once per year Twice per year Does not visit regularly

Who is your child's dentist? _____

Is your child drinking water that is fluoridated?

Yes No

Is your child taking a fluoride supplement?

Yes No

Has your child had fluoride varnish applied to their teeth in the last 6 months?

Yes No Not previously indicated or recommended.

Does your child continually drink from a bottle or sippy cup throughout the day or sleep with a bottle or sippy cup?

Yes No

If so, what is usually in the bottle or sippy cup?

Water Milk Juice

Does your child snack frequently?

Yes No

Have you, the parent or primary caregiver, had any cavities in the last 12 months?

Yes No

Do you, the parent or primary caregiver, see a dentist on a regular basis?

Yes No

Is your child eligible for Medicaid?

Yes No

Do you have concerns about the way your child hears?

Yes No

If so, describe _____

Do you have concerns about the way your child speaks?

Yes No

Do you have concerns about the way your child sees?

Yes No

If so, describe _____

Does your child hold objects close to focus?

Yes No

Do you have concerns about the way your child's eyes look?

Yes No

If so, describe _____

Has your child ever had an injury to their eye?

Yes No

If so, describe _____

How many hours a day does your child spend being physically active?

_____

Is your family physically active together?

Yes No

How many hours a day does your child spend watching TV or other electronic device screen? For example, computer, tablet, or game console?

2 hours or less 3 hours or more

Do you or anyone else have concerns about your child's behavior?

Yes No

If so, describe _____

Do you set limits for your child?

Yes No

Are the limits the same with each caregiver?

Yes No

Do you praise your child for good behavior?

Yes No

Do you teach your child that behaviors like biting and hitting are not ok?

Yes No

Are your having difficulties with your child's tantrums?

Yes No

When your child rides in a care, do you use a car seat?

Every time Occasionally Rarely Never

Where in the car is the car seat located?

Back seat Front seat

Which way does the car seat face?

Forward Rear

Are there working smoke detectors in the house?

Yes No

Are there working carbon monoxide detectors in the house?

Yes No

Do you have a fire escape plan?

Yes No

Are there any funs in your home or where your child spends time?

Yes No

If so, are the guns unloaded and locked away?

Yes No

Are your stairs gated at the top and bottom?

Yes No

Is your child kept away from the stove, oven, heater, fire place etc?

Yes No