UW Medicine
UW NEIGHBORHOOD CLINICS

15 Month Old Well Child Visit

Child's Name:____________________________ Child's age ______________ Date:_________________
Person completing the form:_____________________ Relationship to the patient:____________________

Has your child had any illnesses, hospitalizations or surgeries since last visit here? (YES) (NO)

Review of Nutrition:

	Yes	No
Is your child drinking whole milk, limited to no more than 20oz per day?	( )	( )
Have you weaned your child off the bottle?	( )	( )
Is juice/sugary drinks limited to 0-1 servings per day?	( )	( )
Does your child eat a variety of fruits/vegetables/dairy/meat?	( )	( )
Does your child take a supplement that contains vitamin D regularly?	( )	( )
On average, does your child eat fast food one or more times per week?	( )	( )

Family and Social History:

	Yes	No
Are there any major illnesses in the family that we are not aware of?		
Are there any major stressors in the family? (Illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:

	Yes	No
How many hours of TV or videos is your child expose to per day?	( )	( )
Does your child always ride in a car seat, in the back seat, facing backwards?	( )	( )
Does anyone who cares for your child or anyone at home smoke?	( )	( )
Does your child have at least one hour of active play per day?	( )	( )
Has your child had close contact with anyone who has tuberculosis (TB) or is at high risk for TB (visited Africa, Asia, Latin America, Caribbean country, been homeless or jailed, IV drugs user, HIV positive)?	( )	( )

Oral Health:

Have you found a dentist for your child yet?	( )	( )

Behavioral/Mental Health:

Does your child have a regular sleep routine?	( )	( )
Does your child sleep well without snoring?	( )	( )
Do you have any concerns about how your child is learning, developing and behaving?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
If yes, you need assistance finding a daycare?	( )	( )