UW Medicine
UW NEIGHBORHOOD CLINICS

15 Month Old Well Child Visit

Child's Name ______________________ Child's Birth Date ______________________

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition	**Yes**	**No**
Is your child drinking whole milk, limited to 2-3 cups per day?	( )	( )
Is your child weaned off of the bottle and drinking from a cup?	( )	( )
Does she/he eat a variety of fruits, vegetables, cereals, dairy products, meats and table foods?	( )	( )
Is juice limited to 0-1 cups per day?	( )	( )
Are you brushing your child's teeth?	( )	( )
Is your child stooling comfortably?	( )	( )

Sleep	**Yes**	**No**
Can your child sleep through the night?	( )	( )
Does your child sleep in her/his own crib or bed?	( )	( )

Social Screening	**Yes**	**No**
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Is your child in a car seat in the backseat whenever in the car?	( )	( )
Do you have the Poison Control # (800-222-1222) programmed into your phone and/or posted on your refrigerator?	( )	( )
Do you keep your child away from hot objects, such as the stove?	( )	( )
Have you locked up medications and secured unsafe areas in your home?	( )	( )
Was your home built after 1979?	( )	( )
Tuberculosis (TB) risk?		
1. Contact with person who has tuberculosis	( )	( )
2. Your child is immuno-suppressed (HIV, cancer, chronic steroids)	( )	( )
3. Birth or travel to endemic Tuberculosis areas (Africa, Asia, Latin America, Caribbean)	( )	( )
4. Regular contact with adults at high risk for TB (Homeless, Jailed, Illegal drug user, HIV positive person, migrant farm worker, nursing home resident)	( )	( )

Developmental Screening	**Yes**	**No**
Does your child feed her/himself?	( )	( )
Does your child walk well?	( )	( )
Can your child scribble?	( )	( )
Does she/he know "Mama," "Dada," and 3-6 other words?	( )	( )
Can your child tell you what she/he wants without crying/whining (points or uses words instead)?	( )	( )
Can your child point to named body parts and name pictures in a book?	( )	( )
Does your child enjoy having books read to him/her?	( )	( )

Has your child had any significant illnesses since the last time we saw you? If yes, please describe:

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Are there any new stresses on your family since the last time we saw you? If yes, please describe:

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Current concerns not listed above:

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