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)

Nutrition:	**Yes**	**No**
Is your child drinking whole milk, limited to no more than 20 ounces per day?	☐	☐
Have you weaned your child from the bottle?	☐	☐
Is juice or sugary drinks limited to 0-1 servings per day?	☐	☐
Does your child eat a variety of fruits/vegetables/dairy/meat?	☐	☐
Does your child regularly take a supplement that contains vitamin D?	☐	☐
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 already 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 exposed to per day? _____		
Does your child always ride in a car seat, in the back seat, facing backwards?	☐	☐
Do you, anyone in your home, or anyone who cares for your child 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 user, HIV positive)?	☐	☐

Oral Health:	**Yes**	**No**
Have you found a dentist for your child yet?	☐	☐

Behavioral/Mental Health:	**Yes**	**No**
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, do you need assistance to find a suitable program?	☐	☐

PLACE PATIENT LABEL HERE