Stanford Children's Health

Patient Name/Date of Birth: _____

Well Baby Check: 15 month visit questionnaire

Interval History:

Has your child had any major illnesses, ER or Urgent Care trips since your last appointment in the office?	No	Yes	
Has your child had any reactions to vaccinations in the past?	No	Yes	

Development:

Can your child scribble with a crayon/pencil?	Yes	No	
Can your child drink from a cup?	Yes	No	
Does your child feed him/herself finger foods?	Yes	No	
Does your child say at least 3 words (e.g. "Hi", "No", "Uh-oh")?	Yes	No	
Does your child say "words" that you don't understand (jargoning)?	Yes	No	
Does your child understand and follow simple commands?	Yes	No	
Can your child walk alone?	Yes	No	
Can he or she bend (stoop) to pick something up and stand up again?	Yes	No	
Can your child crawl up stairs?	Yes	No	N/A
Can your child stack two blocks or objects (one on the other)?	Yes	No	
Do you read to your child regularly?	Yes	No	
Do you have concerns about how your child hears or speaks?	No	Yes	
Do you have any concerns about how your child sees?	No	Yes	
Does your child hold objects close when trying to focus?	No	Yes	
Do your child's eyes appear unusual or seem to cross, drift or be lazy?	No	Yes	
Do your child's eyelids droop or does one eyelid tend to close?	No	Yes	

Dental Health:

Do you help your child brush and floss his/her teeth daily?	Yes	No	
Does your child's primary water source contain fluoride?	Yes	No	Unsure
If no, does your child take a fluoride supplement?	Yes	No	N/A
Do you know a dentist to whom you can bring your child?	Yes	No	

Staying Healthy/Safety/Tobacco Exposure:

Does your child watch TV, play video games, or use a smart phone or tablet?	No	Yes	
Does your home have a working smoke detector?	Yes	No	
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A

If your home has more than one floor, do you have safety guards on the windows and gates for the stairs? Yes No N/A

Does your home have cleaning supplies/medicines/matches locked away? Yes No

Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone? Yes No

Do you always stay with your child when she/he is in the bathtub? Yes No

Do you and your child spend time near water (pool, river or lake)? No Yes

If so, is your child always safely supervised? Yes No N/A

Do you use sunscreen when your child is outdoors? Yes No

Do you always place your child in a rear-facing car seat in the back seat? Yes No

Is your car seat the right one for the age and size of your child? Yes No

Do you always check for children before backing your car out? Yes No

Does your child spend time in a home where a gun is kept? No Yes Skip

If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun? Yes No N/A

Does your baby spend time with anyone who smokes? No Yes

Risk Assessment for Lead Exposure:

Does your child participate in any publicly supported programs (Medi-Cal, CHDP, Healthy Families, WIC)? No Yes

Does your child live in or regularly visit a house or child care facility built before 1950? No Yes

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)? No Yes

Does your child have a sibling or playmate who has or did have lead poisoning? No Yes

Does your child take any imported remedies or supplements? No Yes

Sleep:

How many hours does your child sleep at night? ____ hours

How many hours does your child nap throughout the day? ____ hours

Does your child sleep through the night without feeding? Yes No

Nutrition/ Physical Activity:

How much milk does your child drink? _____ oz per day. Type: [breast milk] [formula] [whole milk] [other _____]

How much juice does your child drink in 24 hours? ____ oz

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Is your child eating fruits and vegetables at least two times per day?	Yes	No
Does your baby drink or eat 3 servings of calcium-rich foods daily, such as milk, soy milk, cheese, yogurt, or tofu?	Yes	No
Does your child eat high fat foods such as fried foods, chips, ice cream or pizza more than once per week?	No	Yes
Does your child drink soda, sports drinks, energy drinks or other sweetened drinks?	No	Yes
Does your child eat meat (such as chicken, fish, beef or pork)?	Yes	No
Does your child play actively most days of the week?	Yes	No
Do you have any concerns about your child's weight or feeding?	No	Yes

Elimination:

Does your child have bowel movements on a regular basis with a normal (soft) consistency?	Yes	No

Please list any medications or supplements your child is taking: _____

Who lives in the home with your child? _____

Who provides daytime care for your child? _____

Please list any new major family medical issues: _____

Please list any known allergies to medicines: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

_____

Signature: _____Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

Ver.5-7-15