15 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have any concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES

Review of Systems

3	Do you have any concerns about your child's hearing?	NO	YES
4	Do you have any concerns about your child's vision?	NO	YES

Feeding/Nutrition

5	Is your child taking formula or milk well?	YES	NO
	a. Which kind of milk or formula?		
	b. How much milk per day?		
6	Is your child getting 5 servings of fruits and vegetables daily?	YES	NO
7	When your child eats grains (cereal, bread, pasta, crackers, waffles, rice, etc) are they mostly whole grains?	YES	NO
8	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO
9	Does your child still drink from a bottle?	NO	YES
10	Does your child drink juice or other sweetened drinks?	NO	YES
11	Do you give your child any vitamins or supplements?	NO	YES

Oral Health

12	Is your child seeing a dentist?	YES	NO

Elimination

13	Does your child have any problems with bowel movements (pooping)?	NO	YES

Activity / Exercise / Screen Time

14 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
15 Do you play with your child every day?	YES	NO
16 Do you read to your child every day?	YES	NO

Sleep

17 Does your child sleep through the night?	YES	NO
18 Do you have a bedtime routine?	YES	NO
19 Does your child fall asleep on his own, in his/her own bed?	YES	NO

Development (If you are completing the Ages and Stages questionnaire please skip this section)

20 Does your child know at least one body part?	YES	NO
21 Does your child bring things over to show you?	YES	NO
22 Does your child babble a lot?	YES	NO
23 Does your child say 4-5 words clearly?	YES	NO
24 Does your child understand and follow simple commands?	YES	NO
25 Does your child walk well?	YES	NO
26 Can your child scribble?	YES	NO
27 Does your child copy things you do?	YES	NO

Social Stressors

28 Have there been any major changes or stresses in your family recently?	NO	YES	
29 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
30 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
31 Does anyone in your life ever hurt you or your children?	NO	YES	

Behavior

32 Do you have any questions about your child's behavior or how to discipline your child?	NO	YES
33 Do you praise your child when he/she is behaving well?	YES	NO

Safety

34 Is the crib mattress at the lowest position?	YES	NO	
35 Does anyone smoke or vape around your child?	NO	YES	
36 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
37 Do you keep plastic bags and latex balloons away from your child?	YES	NO	
38 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO	
39 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
40 If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15-30 minutes?	YES	NO	DOESN'T APPLY
41 Is there a swimming pool, pond or lake near your home?	NO	YES	
a. If yes, is it secured so that your child cannot access it?	YES	NO	DOESN'T APPLY
42 Do you have the number for Poison Control? (1-800-222-1222)	YES	NO	

Lead

43 Is your child regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
44 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES