

15 Month Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child's health that you would like to discuss today?

What is your child's health Status? **Good Fair Poor**

Has your child been to the emergency room in the past 12 months: **Yes No**

If yes, list why: _____

Has your child been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: _____

Has your child ever had any reactions to vaccines / immunizations: **Yes No**

Has your child seen a dentist in the last 6 months: **Yes No**

How many times a day does your child brush their teeth? ____ How many times a day do they floss? ____

HOME and FAMILY

Who does the child live with: _____ How many brothers and sisters does he/she have? _____

What do you live in? _____ How many bedrooms are in your home? _____

Does your child share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your child's Father Involved in his/her care? **Yes No**

How is your child's relationship with his brothers and/or sisters? **Good Fair Poor N/A, only child**

What type of discipline is used in the home: **Verbal Time-out Spanking Other:** _____

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _____

15 Month Well Child Exam Form

GENERAL HEALTH

What type of milk does he/she drink? **Breast milk** **Whole** **2%** **1%** **Fat free** **Lactose free** **Soy**

How much milk/formula does he/she drink in a day? **< 8oz** **8-16 oz** **16-24 oz** **24-32oz** **> 32oz**

What else does he/she drink and how many glasses a day does he/she drink? **___ Glasses of juice**

___ Glasses of water **___ glasses of caffeinated soda or tea** **___ glasses of decaffeinated soda or tea**

Does your child drink from: **cup** **bottle only** **cup and bottle** **phasing out bottle**

Does your child eat: **table foods** **adequate fruits/vegetables** **meat** **whole grains**

Does your child have any problems with bowel movements, including constipation or diarrhea? **Yes** **No**

Is he/she toilet trained? **Yes** **Daytime only** **In process** **No**

Does he/she have any problems sleeping? **Yes** **No** If yes, what kind of problems? _____

How would you describe your child's temperament? **Happy** **Fussy** **Easy** **Demanding**

Cries when hungry or with needs **Fussy all the time** **Fussy at night** **Fussy but consolable**

Do you have any concerns about:

Your child's development? **Yes** **No**

Your child's behavior? **Yes** **No**

HEARING

Does your child:

Brings objects to you when asked **Yes** **No**

Hears and identifies sounds coming from another room or from outside **Yes** **No**

Gives one word answers to questions **Yes** **No**

Imitates many new words **Yes** **No**

Uses words or more than one syllable (ex. "bottle") **Yes** **No**

VISION

Do you have any concerns about how your child sees **Yes** **No**

Does your child hold objects close when trying to focus? **Yes** **No**

Do your child's eyes appear unusual or seem to cross, drift, or be lazy? **Yes** **No**

Do your child's eyelids droop or does one eyelid tend to close? **Yes** **No**

Have your child's eyes ever been injured? **Yes** **No**

15 Month Well Child Exam Form

Check off each task that your child is able to do:

- | | | |
|--|---|--|
| <input type="checkbox"/> Walks well | <input type="checkbox"/> Feeds self | <input type="checkbox"/> Understands simple |
| <input type="checkbox"/> Stoops and recovers | <input type="checkbox"/> Scribbles spontaneously | <input type="checkbox"/> command |
| <input type="checkbox"/> Crawls up steps | <input type="checkbox"/> Uses 2 words | <input type="checkbox"/> Immature babbling |
| <input type="checkbox"/> Removes clothing | <input type="checkbox"/> 3 words other than | <input type="checkbox"/> Imitates activity |
| <input type="checkbox"/> Scribbles | <input type="checkbox"/> mama/dada | <input type="checkbox"/> Drinks from cup |
| <input type="checkbox"/> Dumps cup | <input type="checkbox"/> Points to 1-3 body parts | <input type="checkbox"/> Helps with simple tasks |
| <input type="checkbox"/> Uses cup | | |

GENERAL SAFETY

Does your child always use a car seat? **Yes No**

Is your home childproofed? **Yes No**

Do you have these things in your home:

Smoke detector **Yes No**

Carbon monoxide detector **Yes No**

Fire extinguisher **Yes No**