PEDIATRIC HEALTH MAINTENANCE – 15 Months

Parent Questionnaire

General

Do you have any concerns or worries about your child or your child's development? _____ No _____ Yes

If yes, please specify: _____

Is your child in daycare or the care of a babysitter? _____ No _____ Yes

Do your child's eyes ever appear to cross or drift apart? _____ No _____ Yes

Feeding and Sleeping

What type of milk does your child drink? _____ How much? _____

Are you giving your baby any vitamins? □ No □ Vitamin D □ Iron _____

Is your child taking any vitamins?

Does your child eat a good variety of foods (meat/protein, vegetables, grains, fruit)? _____ Yes _____ No

Have you begun to brush your child's teeth? _____ Yes _____ No

Does your child sleep through the night? _____ Yes _____ No

Does your child sleep with a bottle? _____ No _____ Yes

Development

Does your child try to say one or two words besides "mama" or "dada," like "ba" for ball or "da" for dog? _____ Yes _____ No

Does your child look at a familiar object when you name it? _____ Yes _____ No

Does your child point to ask for something or to get help? _____ Yes _____ No

Does your child try to use things the right way, like a phone, cup, or book? _____ Yes _____ No

Can your child take a few steps on their own? _____ Yes _____ No

Does your child use their fingers to feed themself some food? _____ Yes _____ No

Safety

Do you have safety caps on all medicines, vitamins, and herbal products? _____ Yes _____ No

Do you keep medicines, household cleaners, and sharp objects in locked drawer or cabinets? _____ Yes _____ No

If you have stairs, do you use a gate at the top and bottom of the stairway? _____ Yes _____ No

Do you know what to do if your child eats or drinks a poisonous substance? _____ Yes _____ No

Do you know what to do if your child is choking? _____ Yes _____ No

Do you give your child hard raw vegetables, hard candy, gum, nuts, or popcorn? _____ No _____ Yes

Do you leave your child alone in the bathtub? _____ No _____ Yes

Does your child play with latex balloons or plastic wrappers? _____ No _____ Yes

Do you have a firearm in your home? _____ No _____ Yes

If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them? _____ No _____ Yes

Are you afraid of your partner or anyone close to you? _____ No _____ Yes

Do you feel overly stressed or unsupported? _____ No _____ Yes

_____ _____

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME

VIRGINIA MASON FRANCISCAN HEALTH

Pediatric Health Maintenance – 15 Months

CNPEDWLLCK

VMMC99220 (05-24)

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