Pediatric Health Maintenance: 15 Months
Parent Questionnaire

Virginia Mason

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health ☐ I'd like to discuss		
☐ Yes	☐ No	Is your child in daycare or the care of a babysitter?
☐ Yes	☐ No	Do your child's eyes ever appear to cross or drift apart?

Feeding and Sleeping ☐ I'd like to discuss		
What type of milk does your child drink? ☐ Whole ☐ 1-2% ☐ Skim ☐ Other		
How much milk does your child drink each day?		
☐ Yes	☐ No	Does your child eat a good variety of foods (meat, vegetables, grains, and 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?

Development ☐ I'd like to discuss		
☐ Yes	☐ No	Does your child follow simple instructions?
☐ Yes	☐ No	Does your child respond to his or her name?
☐ Yes	☐ No	Does your child say any words?
☐ Yes	☐ No	Does your child walk without support?
☐ Yes	☐ No	Does your child imitate actions like talking on the phone?
☐ Yes	☐ No	Does your child point at things of interest (a dog or an airplane)?
☐ Yes	☐ No	Does your child point to get something he or she wants?
☐ Yes	☐ No	Will your child scribble if given a pen and paper?

Safety ☐ I'd like to discuss		
☐ Yes	☐ No	Does your child ride in a car seat, in the back seat of car?
☐ Yes	☐ No	Do you have all safety caps on all medicines, vitamins, and herbal products?
☐ Yes	☐ No	Do you keep medicines, household cleaners, and sharp objects in locked drawers 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 raw vegetables, hard candy, gum, nuts, or popcorn?
☐ Yes	☐ No	Do you leave your child alone in the bathtub?
☐ Yes	☐ No	Does your child play with latex balloons or plastic wrappers?
☐ Yes	☐ No	Is your child ever in the yard when the lawnmower is in use?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 15 Months form.

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME & ID #