*Office Use Only*

VFC: [ ] V02 -- MDD
[ ] V03 – No Ins
[ ] V04 -- Native
[ ] V07 -- AVAP
INSURANCE:
Copay / Co-ins

Statement Balance

# 15 Month Well Child Questionnaire

**Note that "well child visits"** are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. *If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.*

*Office Use Only*

WT: _____kg

WT: _____lb

HT: _____

OFC:_____

Temp: _____

Resp: _____

Pulse: _____

Oxygen: _____

**Child's Name: _____ Birth Date: _____**

Who is your child's primary care physician? _____

Do you have any concerns about your child today? _____

Is your child on any medicine/ vitamins? Yes / No. Which ones/dose? _____

Any allergies to medicines, foods, latex, etc.? Yes / No. Which ones? _____

Has your child had any difficulty with past immunizations? Yes / No. If yes, which ones? _____

Has your child had any surgeries? Yes / No. If yes, describe: _____

Has your child been hospitalized overnight? Yes / No. Is yes, why: _____

**Health:**

Is your baby exhibiting any of the following symptoms?

| | | | |
|---|---|---|---|
| Ear Pain / Ear Pulling | Yes / No. If yes, how long _____ | Fever | Yes / No. If yes, how long _____ |
| Ear Drainage | Yes / No. If yes, how long _____ | Cough | Yes / No. If yes, how long _____ |
| Eye Drainage | Yes / No. If yes, how long _____ | Diarrhea | Yes / No. If yes, how long _____ |
| Decreased Appetite | Yes / No. If yes, how long _____ | Vomiting | Yes / No. If yes, how long _____ |
| Constipation / Gas | Yes / No. If yes, how long _____ | Rash | Yes / No. If yes, how long _____ |
| Urinary Symptoms | Yes / No. If yes, how long _____ | Sleep Problems | Yes / No. If yes, how long_ _____ |

**Nutrition:**

(Circle): Whole milk 2% 1% Skim Soy Other:_____ | How many total ounces of **milk** does your child consume per day? _____

If 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of other dairy products does your child consume each day? _____ # of meals / day_____ # of snacks / day _____

Does your child eat a reasonable amount and variety of table foods? Yes / No.

Does your child eat any of the following (please circle): Cereal | Vegetables | Fruits | Meat | Pasta | Fish

Is your child breastfeeding? Yes / No. How long and how many times per day? _____

Circle your child's water supply source: City Bottled Well.

Is your child on a cup AND off the bottle? Yes / No. Does your child use a pacifier? Yes / No.

How many ounces of juice, soda or other sugar-sweetened beverages does your child consume each day? _____

**Sleep and Elimination:**

How many hours straight does your child sleep at night? _____

Does your child nap daily? Yes / No. If yes, how often and how long? _____

Does your child have any problems with urinating? Yes / No Any problems with stooling? Yes / No

How many wet diapers per day? _____ How many stools? _____

Is your child toilet trained? Yes / No / Attempting Any issues with training? _____

**Social:**

Any changes in your child's environment? (new home, pets, daycare, etc.)_____

Is this child yours by: __ birth __ adoption __ marriage (stepchild) other _____

Who lives in the household with the child? (Please list for all households if more than one) **Please specify relationship to child**

_____

Marital status of Parents: __ married __ unmarried __ separated __ divorced __living together __ other: _____

Does this child live with you full-time? ____ Other? (Please describe)_____

Who is the primary caretaker in the home? _____ Name of Dentist? _____

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? _____

Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _____

Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _____

Is your child in daycare? Yes / No. If yes, where/who? _____

Do you have any pets in your home? Yes / No. Which kind/how many? _____

Any food allergies in your family? Yes / No. If yes, who and to what? _____

Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____

**This form completed by: _____ Relationship to Child: _____ Today's Date_____**