**18 Month Well Child Questionnaire**

*Office Use Only*

VFC: [ ] V02 -- MDD

 [ ] V03 -- No Ins

 [ ] V04 -- Native

 [ ] V07 -- AVAP

INSURANCE:

 Copay / Co-ins

Statement Balance

*Office Use Only*WT: \_\_\_\_\_\_\_kg \_\_\_\_\_\_\_lb

TEMP:\_\_\_\_\_\_\_ OFC:\_\_\_\_\_\_

Length:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TECH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any concerns about your child today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child on any medicine? 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 child exhibiting any of the following symptoms?

Ear Pain / Ear Pulling Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fever Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Headache Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Neck Pain Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Cough Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Decreased Appetite Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Vomiting Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdominal Pain Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Diarrhea Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary Symptoms Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Rash Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Problems Yes / No. If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Joint Pain Yes / No. If yes, how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition**Whole milk? Yes / No. Ounces per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Is your child still breastfeeding? Yes / No. 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.

Can your child use an open cup? Yes / No. Does your child use a pacifier? Yes / No.

How many ounces of juice, soda and other sugar-sweetened beverages does your child consume each 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 on vitamins? Yes / No. Which brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social**Any changes in your child’s environment? (new home, pets, daycare, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in the household with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary caretaker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does anyone in the family smoke? Yes / No. If yes, who?\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Mom working? Yes / No. Full time / Part Time Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Dad working? Yes / No. Full time / Part Time Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child in daycare? Yes / No. If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pets? Yes / No. If yes, which kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Dentist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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. # of stools / day \_\_\_\_\_\_\_\_

**This form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**