



15 Month Well Child Questionnaire

Office Use Only

VFC: [] V02 -- MDD
 [] V03 -- No Ins
 [] V04 -- Native
 [] V07 -- AVAP

INSURANCE:
 Copay / Co-ins
 Statement Balance

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WT: _____ kg
 WT: _____ lb
 HT: _____
 OFC: _____
 Temp: _____
 Resp: _____
 Pulse: _____
 Oxygen: _____
 Lead: _____ Hgb: _____

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:** _____

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 _____