Woodinville Pediatrics 15 Month Questionnaire

Patient Name:_____ Date:_____

Parental concerns this visit: _____
_____

Current Medications: _____
Current Allergies: _____

Family
Parents working outside home ____mother ____father
Child Care ____yes ____no Type_____
Changes since last visit _____

Diet
Nutrition: ___Breast ___Bottle ___Cup
Milk _____ Ounces per day _____
Source of water _____ Vitamins/Fluoride_____
Juice Amount_____
Diet Concerns ___yes ___no
Diet comments _____

Bowel/Bladder
Stool Concerns ____yes ____no
Stool Consistency ____hard ____soft
Urination Concerns ____yes ____no

Sleep
Back sleeping ____yes ____no
Location ____co-sleep ____crib ____co-sleep & crib
Duration ____ < 3 hrs ____ 3-6 hrs ____ > 6 hrs

Tobacco Exposure ____yes ____no

Behavior Concerns ____yes ____no

Activity (playtime, no TV) _____

Development
Social Emotional: ___Tries to do what you do
___Helps in the house
___Listens to a story
Communication: ___ Speaks 2-3 words
___ Brings toys over to show you
Cognitive: ___Scribbles ___Follows simple commands
Physical : ___Bends down without falling ____Walks well
___Puts block in a cup ___Drinks from a cup with very little spilling

Additional comments: _____

_____