Woodinville Pediatrics 18 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 (play time, no TV) _____

Development
Social Emotional: ___Helps in the house
___Laughs in response to others
Communication: ___ Speaks 6 words
Cognitive: ___Knows name of favorite book ___Points to 1 body part
Physical : ___Stacks 2 small blocks ___Runs
___Walks up stairs ___Uses spoon/cup w/o spilling most of time

Additional comments: _____

_____