Well Child Check: 15 Month Visit

marinhealth Medical Network | UCSF Health

Child's Name: _____ DOB: _____ Date: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT ALL PAGES.

Does your child walk?	YES	NO	UNSURE
Does your child run?	YES	NO	UNSURE
Can your child feed him/herself with a spoon?	YES	NO	UNSURE
Does your child do pretend play (such as pretend to talk on the phone)?	YES	NO	UNSURE
Does your child play games with you?	YES	NO	UNSURE
Can your child point to come parts of his/her body when asked?	YES	NO	UNSURE
Can your child use as least 4 words?	YES	NO	UNSURE
Is your child completely weaned from the bottle?	YES	NO	UNSURE
Does your child usually drink more than 4 oz. of juice or sweetened drinks daily?	YES	NO	UNSURE
Is your baby getting breast milk or other milk? **Breast Milk Formula Other**			
How much breast milk, formula or other milk does your child drink in 24 hours? _____ oz. _____feeds			
Does your child sleep through the night, without feeding?	YES	NO	UNSURE
Do you read to your child regularly?	YES	NO	UNSURE
Is your house child proofed?	YES	NO	UNSURE
Do you usually protect your child with sunscreen/hats other measures when outdoors?	YES	NO	UNSURE
Do you have the poison control number (800-222-1222) posted at home?	YES	NO	UNSURE
Who provides daytime care for your child?			

Does your water contain fluoride?	YES	NO	UNSURE
Is your child on any medications or supplements including vitamins? If so, please list below:			
Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds?	YES	NO	UNSURE
Do you have any international travel plans prior to you child's second birthday? If so, when and where?			

Do you have any other concerns about your child's development or any other concerns you would like to discuss with the provider? If YES, please describe below: