15 Month Well Child Check Name_____

Allergies_____Current Meds_____

Is your child healthy?	**Yes**	**No**_____
Has your child had any recent illness or injuries?	No	Yes_____
Does your child stool at least once daily/have 4-6 wet diapers/day?	Yes	No_____
Does your child eat a balanced diet?	Yes	No_____
Is your child having any feeding problems?	No	Yes_____
If breastfeeding , how often is your child nursing?		_____
Does your child drink whole milk? If so, how many oz/day?_____		
How many meals per day does your child eat?		_____
Does your child still take a bottle?	No	Yes
Does your child take a vitamin?	Yes	No
Is there Fluoride in your drinking water? (city water=yes)	**Yes**	**No**
Does your family eat a balanced diet?	Yes	No
Has there been any recent change to your family structure?	No	Yes_____
Does anyone smoke in or out of the home?	No	Yes
Is your child in childcare?	No	Yes_____
Is your child an excessively picky eater?	*No*	*Yes*_____
Do you have mealtime battles?	*No*	*Yes*_____
Does your child ride in a rear facing car seat?	*Yes*	*No*
Does your child sleep thru the night?	*Yes*	*No*_____
Does your child take naps?	*Yes*	*No*_____

*Do you have any other concerns?*_____

_____

Development (Do not complete if given the Ages and Stages Questionnaire)

Does your child say at least 3-6 words?	Yes	No
Does your child listen to stories?	Yes	No
Does our child point to at least one body part?	Yes	No
Does your child use gestures to indicate what they want?	Yes	No
Does your child understand simple commands?	Yes	No
Does your child walk?	Yes	No
Does your child climb stairs?	Yes	No
Does your child stack blocks?	Yes	No
Does your child feed him/herself with his/her fingers?	Yes	No
Does your child drink from a cup?	Yes	No
Does your child look for fallen objects?	Yes	No
Does your child engage in play with other children?	Yes	No