OPTUM®

Department of Pediatrics
1-719-522-1134 TTY **711**

Well-check questionnaire

15 month well-check

Patient name: ________________________ **DOB:**_____________________ **Today's date:** ________________

Medications:____________________________________ **Allergies:** ___________________________________

Mother's maiden name: ____

Of wet diapers a day:____________________________ # Of stools a day: _____________________________

Is your child drinking whole milk? ☐ No ☐ Yes
Does your child eat primarily table foods? ☐ No ☐ Yes
Do you offer fruits and vegetables daily? ☐ No ☐ Yes
Do you limit daily juice intake and sugar/sweets? ☐ No ☐ Yes
Do you give your child any soda? ☐ No ☐ Yes
Does your child eat fast food? ☐ No ☐ Yes
Is your child sleeping through the night? ☐ No ☐ Yes
Does your child sleep in a crib or bed? ____
Do you brush your child's teeth once or twice daily? ☐ No ☐ Yes
Does your child watch TV or videos? ☐ No ☐ Yes
Is your child always in a car seat when riding in a vehicle? ☐ No ☐ Yes
Is your hot water heater turned down to 120? ☐ No ☐ Yes
Does your home have smoke and carbon monoxide detectors? ☐ No ☐ Yes
Is your baby exposed to secondhand smoke at home, in cars or at daycare? ☐ No ☐ Yes
Do you have outlet protectors and safety gates? ☐ No ☐ Yes

Does your baby:
Stand alone and walk? ☐ No ☐ Yes
Clap and wave bye-bye? ☐ No ☐ Yes
Drink from a sippy cup? ☐ No ☐ Yes
Follow simple directions? ☐ No ☐ Yes
Use index finger to point to things? ☐ No ☐ Yes

Is your baby:
Quick to agitation? ☐ No ☐ Yes
Difficult to soothe? ☐ No ☐ Yes
Hitting, biting, screaming or throwing tantrums? ☐ No ☐ Yes

Any questions or concerns: ____

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