14-15 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have any concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES

Feeding/Nutrition

3	Is your child breastfeeding?	YES	NO	Never breastfed
	a How often?			
4	Is your child drinking formula or milk well?	YES	NO	
	a Which kind of milk or formula?			
5	Does your child eat fruits or vegetables at every meal?	YES	NO	
6	Do you feed your child mostly whole grains?	YES	NO	
7	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO	
8	Does your child still drink from a bottle?	NO	YES	
9	Does your child drink juice or other sweetened drinks?	NO	YES	
10	Do you give your child any vitamins or supplements?	NO	YES	

Oral Health

11 Are cavities a problem for you or anyone in your family?	NO	YES
12 Does your child sleep with a bottle?	NO	YES
13 Does your child breast or bottle-feed during the night?	NO	YES
14 Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
15 Do you have a dentist for your child?	YES	NO
16 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

17 Does your child have any problems with bowel movements (pooping)?	NO	YES

Activity/Exercise/Screen time

18 Does your child have screen time (smartphone, tablet, TV)?	NO	YES
19 Do you play with your child every day?	YES	NO
20 Do you read to your child every day?	YES	NO

Sleep

21 Does your child sleep through the night?	YES	NO
22 Do you have a bedtime routine?	YES	NO
23 Does your child fall asleep on his/her own and in his/her own bed?	YES	NO

Social Stressors

24 Do you feel that you receive the support you need?	YES	NO	
25 Have there been any major changes or stresses in your family recently?	NO	YES	
26 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
27 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
28 Do you have any worries or concerns about childcare?	NO	YES	
29 Does anyone in your life ever hurt you or your children?	NO	YES	

Behavior

30 Does your child have a lot of tantrums?	NO	YES
31 Do you have any questions about how to discipline your child?	NO	YES
32 Do you praise your child when he/she is behaving well?	YES	NO

Development
(If you are completing the Ages and Stages questionnaire please skip this section)

33 Does your child know at least one body part?	YES	NO
34 Does your child let you know when he/she wants something?	YES	NO
35 Does your child bring things over to show you?	YES	NO
36 Does your child babble a lot?	YES	NO
37 Does your child say 4-5 words clearly?	YES	NO
38 Does your child understand and follow simple commands?	YES	NO
39 Does your child walk well?	YES	NO
40 Can your child scribble?	YES	NO
41 Does your child copy things you do?	YES	NO
42 Can your child listen to a story?	YES	NO

Safety

43 Is the crib mattress at the lowest position?	YES	NO
44 Does anyone smoke or vape around your child	NO	YES
45 Do you have working smoke detectors and carbon monoxide detectors in your home?	YES	NO
46 Do you keep plastic bags and balloons away from your child?	YES	NO
47 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO
48 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO
49 Do you apply sunscreen if child is in the sun for more than 10 minutes?	YES	NO
50 Is there a swimming pool, pond, or lake near your home?	NO	YES

Lead

Question		
51 Is your child regularly in a house built before 1978?	NO	YES
a Is there any peeling or chipping paint?	NO	YES
b Has there been any recent or ongoing remodeling or do you plan to do any remodeling?	NO	YES
52 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Review of Systems

Question		
53 Do you have any concerns about your child's hearing?	NO	YES
54 Do you have any concerns about your child's vision?	NO	YES