15 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your child's…

1. Excessive spitting or vomiting? ☐ Yes ☐ No
2. Bowel movements ☐ Yes ☐ No
3. Congestion or wheezing? ☐ Yes ☐ No
4. Skin color or rashes (circle one)? ☐ Yes ☐ No
5. Overall development? ☐ Yes ☐ No

Answer the following:

6. Is your child exposed to tobacco smoke? ☐ Yes ☐ No
7. Were there any problems with immunizations in the past? ☐ Yes ☐ No
8. Have you been sad, depressed or crying excessively? ☐ Yes ☐ No
9. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No
10. Is your water source from a well? ☐ Yes ☐ No

Does your child…

11. Say 5 words (or more)? ☐ Yes ☐ No
12. Understand his/her name and the word "No"? ☐ Yes ☐ No
13. Become shy or anxious with strangers? ☐ Yes ☐ No
14. Finger feed him/herself well ☐ Yes ☐ No
15. Point to one or more body parts? ☐ Yes ☐ No
16. Drink from a cup? ☐ Yes ☐ No
17. Stand alone? ☐ Yes ☐ No
18. Walk well? ☐ Yes ☐ No
19. Move all extremities equally well? ☐ Yes ☐ No

Answer the following:

20. Do you have smoke alarms? _____ Carbon monoxide detectors? _____

21. Does your child ride in a rear-facing infant car seat? ☐ Yes ☐ No
22. Do you know infant CPR? ☐ Yes ☐ No
23. Have you put up gates to keep your baby in a safe, enclosed area? ☐ Yes ☐ No
24. September through March visits: Have all caregivers and family members living in the home been vaccinated for the flu this season? ☐ Yes ☐ No
25. Are you giving your child a multivitamin with iron? ☐ Yes ☐ No
26. Breast feeding mothers: Are you taking a multivitamin with iron? ☐ Yes ☐ No
27. Infants on whole milk: Are you giving a multivitamin with iron? ☐ Yes ☐ No
28. Is your child eating all food groups: fruits, meats, and vegetables? ☐ Yes ☐ No
29. How many ounces of milk does your child drink in one day? _____ What kind? _____
30. How many ounces of juice does your child drink in one day? _____

15 Month Questionnaire

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? ..... ☐ Yes ☐ No
3. Was your child or any family members born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ..... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ..... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk or eaten unpasteurized cheese? ..... ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your child is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months ..... ☐ Yes ☐ No
2. Your child is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant ..... ☐ Yes ☐ No

Lead Screening:

Does your child…

1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) ..... ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? ..... ☐ Yes ☐ No
3. Have a sibling or playmate who now has or did have lead poisoning? ..... ☐ Yes ☐ No
4. Is your child a refugee from another country? ..... ☐ Yes ☐ No
5. Does your child have their health insurance provided by Medicaid or INtotal Health? . ☐ Yes ☐ No

Name and Ages of Brothers_____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ..... ☐ Yes ☐ No

_____

_____

_____

_____

_____