OBERLIN ROAD PEDIATRICS

Well Child Check: 15 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? □ No □ Yes: _____

Does your baby have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does your baby see any specialists outside of ORP? □ No □ Yes: _____

Does your water contain fluoride? (City water contains fluoride) □ Yes □ No

Nutrition:

What type(s) of milk is your child drinking? □ Whole milk □ Breast milk □ Other_____

Are they usually getting 2-3 servings of dairy a day (8 oz milk=1 serving)? □ Yes □ No

Are they usually drinking MORE than 24 oz of milk a day? □ No □ Yes

Is your child completely off the bottle? □ Yes □ No

Are they eating iron rich foods daily (meat, beans, iron vitamin, cheerios/cereal)? □ Yes □ No

Does your child….

Copy other children while playing, like taking toys out of a container when another child does?	Yes	No
Show you an object that he likes?	Yes	No
Clap when excited?	Yes	No
Hug a stuffed doll or other toy?	Yes	No
Show you affection (hugs, cuddles, or kisses you)?	Yes	No
Try to say 1-2 words besides mama or dad like "ba" for ball or "da" for dog?	Yes	No
Look at a familiar object when you name it?	Yes	No
Follow directions given with both a gesture and words. For example, he gives you a toy when you hold out your hand and say, "Give me the toy"?	Yes	No
Points to ask for something or to get help?	Yes	No
Try to use things the right way, like a phone, cup, or book?	Yes	No
Stack at least 2 small objects, like blocks?	Yes	No
Take a few steps on his own?	Yes	No
Use fingers to feed herself some food?	Yes	No

Who lives at home with your child? _____
Are parents: single married divorced separated

Who takes care of your child during the day? _____

Have there been major changes lately in your baby's or family's life? _____
Will your child travel internationally prior to their 2nd birthday? If yes, when and where: _____

Does your child point to something he wants and then watch to see if you see what he's doing?	Yes	No
Does she wave "bye-bye"?	Yes	No
Do you talk to, sing to, and look at books with your child every day?	Yes	No
Does your child have a regular bedtime routine?	Yes	No
Does your child usually sleep well?	Yes	No
Does your child have a blanket, stuffed animal, or toy that he likes to sleep with?	Yes	No
Do you have a TV or an Internet-connected device in your child's bedroom?	No	Yes
Does your child have frequent tantrums?	No	Yes
If your child is upset, do you help distract her with another activity, book, or toy?	Yes	No
Do you praise your child when he is being good?	Yes	No
Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day?	Yes	No
Is your child in a rear facing car seat every time they are in the car?	Yes	No
Do you keep cleaners and medicines locked up?	Yes	No
Do you keep furniture away from windows?	Yes	No
Do you have a gate at the top and bottom of all stairs in your home?	Yes	No
If you have a pool, does it have a locked gate?	Yes	No
Do you keep your child away from the stove?	Yes	No
Do you have working smoke alarms on all floors?	Yes	No
Do you test your smoke alarms once a month?	Yes	No
Do you offer your child a variety of foods including vegetables, fruits, and proteins?	Yes	No
Do you let your child decide what to eat and how much?	Yes	No
Does your child drink sugar sweetened beverages: juice/soda/sports drinks daily?	No	Yes
Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes