15 MONTH OLD

"It makes me feel good when you can be patient with me while teaching me about the way things work."

pediatrics NORTHWEST PS
Mary Bridge Children's
www.pedsnw.net

Patient Name: ____

Person Filling Out Form: ____________________________________

Relationship to Patient: ____________________________________

CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

yes no Does your child take any medications (daily or as needed)? If so, please list: ________________
yes no Has your child had any reactions to medications?
yes no Is your child currently taking any vitamins, supplements, "alternative medicines", or therapies?
yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes no Is your child in day care?
yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes no Has a parent or household member ever had a problem with alcohol or drug use?
yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

yes no Is your child breastfeeding?
yes no Does your child take a bottle?
yes no Does your child use a sippy cup?
yes no Does your child drink anything other than milk and water? If so, what? ________________
yes no Does your child eat food from all 4 food groups?

PREVENTIVE HEALTH

yes no Does your child always ride in a rear facing car seat and in the backseat?
yes no Do you help your child brush their teeth twice daily?
yes no Is your child using screen time for entertainment (TV, tablet, phone, movies, video games, etc.)?
yes no Does your child have outdoor time daily?
yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
yes no Are there smoke alarms, fire extinguishers, and carbon monoxide alarms in your home?
yes no Have those alarms been checked in the past 12 months?
yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
yes no Is your child enrolled in WIC?
On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes no Eyes (crossing, not focusing, drainage, redness)
yes no Hearing
yes no Coughing, noisy or difficulty breathing, or limitation in activity level
yes no Vomiting, swallowing or eating
yes no Stooling (diarrhea, constipation, or blood in the stools)
yes no Extremities (feet, legs, arms, hands)

DEVELOPMENT (please check the things that your child is currently doing)

Gross motor	[ ] Cruises around furniture [ ] Stands alone [ ] Walks [ ] Crawls up stairs
Fine motor	[ ] Feeds self [ ] Stacks two cubes
Social	[ ] Indicates wants without crying [ ] Gives and takes toy
Language	[ ] Hears [ ] Understands any words [ ] Points for needs [ ] Says any words

On the back, please name several activities you enjoy doing with your child.

Revised 6/2021