



## 15 Month Health Maintenance Questionnaire

Patient Name

\_\_\_\_\_

Who accompanied child today?  
(name and relationship to child)

\_\_\_\_\_

\_\_\_\_\_

Who does child live with?

\_\_\_\_\_

\_\_\_\_\_

Any Chronic health problems?

\_\_\_\_\_

\_\_\_\_\_

Concerns about the above health problems?

\_\_\_\_\_

\_\_\_\_\_

New or recent health concerns?

\_\_\_\_\_

\_\_\_\_\_

**Feedings:**

What type of milk is your baby getting?

\_\_\_\_\_

Method of milk feeding?

Cup    Breast    Bottle

Tolerating most Table Foods?

Yes    No

Any concerns with stooling or urination?

\_\_\_\_\_

*If you do not understand any of these questions, please ask your nurse.*

**Sleep pattern:**

Average hours of nighttime sleep: \_\_\_\_\_

Number of naps: \_\_\_\_\_

Length of naps: \_\_\_\_\_

Are there any smokers in the household? \_\_\_\_\_

Please list current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any allergies to medicine? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Does your child:**

Walk well alone? Yes No

Stoop to recover objects from floor? Yes No

Walk backwards? Yes No

Drink from a cup? Yes No

Use 1-3 word vocabulary Yes No

Understand simple directions ? Yes No

Put a block or other object in a cup Yes No

Wave bye-bye? Yes No

Hug parents, beginning to pucker and kiss? Yes No

*If you do not understand any of these questions, please ask your nurse.*