



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?

Over Please

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.