15 month visit

Name _____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your baby's…	**Yes**	**No**
1. Feedings ☐ Breast ☐ Milk….. ……	☐	☐
☐ Solids?……..	☐	☐
2. Excessive spitting or vomiting..……....	☐	☐
3. Bowel Movement…..……..	☐	☐
4. Straining with stools……	☐	☐
5. Straining or crying with voiding…….	☐	☐
6. Congestion or wheezing…….…….	☐	☐
7. Skin color or skin rashes (circle)……	☐	☐
8. Excessive whining, fussing or crying……..	☐	☐
9. Overall development……	☐	☐
10. Sleep habits……..……	☐	☐
Does your child...		
11. Say 3-6 words……...……...…..……..	☐	☐
12. Understand simple commands or requests…….……	☐	☐
13. Listen to a story……...……...……..……	☐	☐
14. Indicate his/her wants by pulling, pointing, grunting..……	☐	☐
15. Point to one or more body parts……..……	☐	☐
16. Become shy or anxious with strangers……...……	☐	☐
17. Feed self with fingers……..…..……..	☐	☐
18. Drink from a cup…….……...……..	☐	☐
19. Cooperate while dressing……..……...……	☐	☐
20. Walk well, stoop and climb stairs...……..☐		☐
21. Stack two blocks……	☐	☐
21. Do you have smoke alarms in your house?……..…	☐	☐
22. Does your child ride in a safety seat in the back seat?……	☐	☐
23. Do you know infant CPR?……....	☐	☐
24. Is your child exposed to cigarette smoke?……..…	☐	☐
25. Is your child attending day care?……...……	☐	☐
26. Does anyone have a gun in the home?……..	☐	☐

Lead Screen

Does your child...		
1. Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative)……...	☐	☐
2. Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (w/in the last 6 months)…	☐	☐
3. Have a sibling or playmate who now had or did have lead poisoning?……	☐	☐
Do you have any concerns you wish to discuss?……..	☐	☐

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