ABC Pediatrics

Fifteen Month Pre-visit Questionnaire

Patient Name_____ Date_____

Bathes: (Daily) (Every other day)

Feeding Routine

Balanced Diet?_____ Picky eater?_____ Cups of milk daily_____ Drinking from bottle?_____

# of stools Daily_____ Interested in potty training? _____ # of hours sleeping at ONE time_____

Developmental Milestones (check all that apply)

☐ Drinks from a cup	☐ Feeds Self	☐ Gives and takes food	☐ Plays ball
☐ Points to pictures in books	☐ Points to body parts	☐ Says 15 words	☐ Scribbles
☐ Stacks blocks	☐ Uses Spoons	☐ Walks Alone	☐ Walks up steps
☐ Helps with certain tasks	☐ Throws objects in play	☐ Uses Jargon	

Lead Test Completed? YES NO

Any other questions or concerns you would like to discuss?

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TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was your child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**
Lead Risk	**Does your child have a sibling or playmate that has had lead poisoning?**	**YES**	**NO**
	Does your child live in or regularly visit a home built before 1978 that being renovated?	**YES**	**NO**
	Does your child live in or regularly visit a house or childcare facility built before 1950?	**YES**	**NO**

Weight_____ Temp_____Height_____ Head Circumference_____