ABC Pediatrics

Eighteen 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? _____

Type of water (bottled/well/city): _____ # of hours sleeping at ONE time_____

Is there any secondhand smoke exposure in your home or car? _____

Current Dentist:_____ Current Daycare:_____

Developmental Milestones (check all that apply)

☐ Uses 6 – 10 words other than names.	☐ Identifies at least 2 body parts.	☐ Engages with others for play.	☐ Helps dress and undress her/himself.
☐ Points to pictures in books.	☐ Points to object of interest to draw attention to it.	☐ Scribbles Spontaneously	☐ Throws small ball a few feet while standing.
			☐ Begins to scoop with spoon.
☐ Walks up with 2 feet per step with handheld.	☐ Sits in a small chair.	☐ Carries toy while walking.	

Lead Test Completed? YES NO

Any other questions or concerns you would like to discuss?

_____

_____

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**

For Office Use Only

Weight_____ Temp_____Height_____ Head Circumference_____ **PLEASE TURN OVER**

M-CHAT

Name: _____DOB:_____Date:_____

INSTRUCTIONS:

Please fill out the following about how your child *usually* is. Please try to answer every question. **If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it.**

1. If you point at something across the room, does your child look at it? YES NO
2. Have you ever wondered if your child might be deaf? YES NO
3. Does your child play pretend or make-believe? YES NO
4. Does your child like climbing on things? YES NO
5. Does your child make unusual finger movements near his or her eyes? YES NO
6. Does your child point with one finger to ask for something or to get help? YES NO
7. Does your child point with one finger to show you something interesting? YES NO
8. Is your child interested in other children? YES NO
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? YES NO
10. Does your child respond when you call his or her name? YES NO
11. When you smile at your child, does he or she smile back at you? YES NO
12. Does your child get upset by everyday noises? YES NO
13. Does your child walk? YES NO
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her ? YES NO
15. Does your child try to copy what you do? YES NO
16. If you turn your head to look at something, does your child look around to see what you are looking at? YES NO
17. Does your child try to get you to watch him or her? YES NO
18. Does your child understand when you tell him or her to do something? YES NO
19. If something new happens, does your child look at your face to see how you feel about it? YES NO
20. Does your child like movement activities? YES NO

Pass_____ Fail_____