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? _______

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

Current Dentist:________________________ Current Daycare:_____________________________________

Developmental Milestones (check all that apply)

- ☐ Uses 3 words other than names.
- ☐ Imitates new gestures.
- ☐ Drops objects into and takes objects out of a container.
- ☐ Speaks in sounds that seem like an unknown language.
- ☐ Drinks from a cup with a little spilling.
- ☐ Squats to pick up objects.
- ☐ Follows directions that do not include a gesture.
- ☐ Points to ask for something or to get help.
- ☐ Crawls up a few steps.
- ☐ Looks around when the parent says, “Where is ___?”.
- ☐ Makes marks with crayons.
- ☐ Begins to run.
- ☐ Imitates scribbling.

Lead Test Completed? YES NO

Any other questions or concerns you would like to discuss?

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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________