



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)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Drinks from a cup | <input type="checkbox"/> Feeds Self | <input type="checkbox"/> Gives and takes food | <input type="checkbox"/> Plays ball |
| <input type="checkbox"/> Points to pictures in books | <input type="checkbox"/> Points to body parts | <input type="checkbox"/> Says 15 words | <input type="checkbox"/> Scribbles |
| <input type="checkbox"/> Stacks blocks | <input type="checkbox"/> Uses Spoons | <input type="checkbox"/> Walks Alone | <input type="checkbox"/> Walks up steps |
| <input type="checkbox"/> Helps with certain tasks | <input type="checkbox"/> Throws objects in play | <input type="checkbox"/> Uses Jargon | |

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

Weight _____ Temp _____ Height _____ Head Circumference _____