

Fifteen Month Visit:

Please answer the following questions. It will help your doctor spend more time discussing those specific issues that concern you.

Does your child walk? Yes No Unsure

Does your child run? Yes No Unsure

Can your child feed him or herself with a spoon? Yes No Unsure

Does your child do pretend play (such as pretend to talk on the phone)? Yes No Unsure

Does your child play games with you? Yes No Unsure

Can your child point to some parts of his body when asked? Yes No Unsure

Can your child use at least 4 words? Yes No Unsure

Is your child completely weaned from the bottle? Yes No Unsure

Is your baby getting breast milk, formula, or other milk? Breast Formula Other milk

How much breast milk, formula or milk does your child drink in 24 hours? _____oz or _____feeds

How many ounces of juice does your child drink in 24 hours? _____oz

Does your child sleep through the night, without feeding? Yes No Unsure

Do you read to your child regularly? Yes No Unsure

Is your house child-proofed? Yes No Unsure

Do you usually use sunscreen for your child when outdoors? Yes No Unsure

Do you have the poison control number (800 222-1222) posted at home? Yes No Unsure

Who provides daytime care for your child? _____

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including fluoride? If so, please list below:

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider? Yes No

If so, what are your concerns?