



18 Month Pre-Visit Questionnaire

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions.

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

YOUR NAME: _____ **RELATIONSHIP:** _____

Do you have any concerns, question or problems that you would like to discuss today? Please describe: _____

Does your child have any allergies? YES/NO If yes, please list: _____

Does your child take any medications? YES/NO If yes, please list: _____

Has your child seen any other healthcare providers? YES/NO If yes, please list: _____

Have there been any recent changes in your family? (check all that apply)

- Death Divorce Other: _____
 Job Change Move _____

FEEDING/NUTRITION

Is your child drinking whole milk? YES/NO If yes, how much in a day? _____ ounces

What else does your child eat? _____

BEHAVIOR/SOCIAL

Review of Systems	Never	Sometimes	All the time
Do you have concerns about your child's development or behavior?			
Does your child have trouble sleeping?			
Does your child have a hard time calming down?			
Risk Assessment			
Does your child live or spend time with anyone who smokes?			
In the past year did you ever worry that your food would run out before you got money to buy more?			

DEVELOPMENTAL MILESTONES: Please put a check beside the things your child is able to do.

- | | |
|---|---|
| <input type="checkbox"/> Runs | <input type="checkbox"/> Uses spoon and cup |
| <input type="checkbox"/> Tries to copy what you do | <input type="checkbox"/> Brings toys or books to show you |
| <input type="checkbox"/> Stacks 2 blocks | <input type="checkbox"/> Listens to a story |
| <input type="checkbox"/> Assists in picking up toys | <input type="checkbox"/> Points to 1 body part |
| <input type="checkbox"/> Says at least 6 words | |