wasatch pediatrics | ST. MARK'S

PT ID: ___________________
PCP: ____________________
Today's Date: ____________

Patient's Name: __________________________
Date of Birth: ____________________________

15 Month Old Parent Observations

Are there any concerns you would like to discuss today? ____

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Feedings:
Any concerns about feedings or weight gain? .... YES NO
Does your child eat well (i.e. has consistent appetite, not took picky)? .... YES NO
Your child's diet consists of: (check all that apply)

☐ Breastmilk ☐ Whole Milk (# of oz/day:______) ☐ Juice (# of oz/day:______)
☐ Fruits ☐ Vegetables ☐ Meats ☐ Grains ☐ Table foods

Any concerns about voiding or stooling? (i.e. constipation, diarrhea) .... YES NO
Any concerns about sleep? .... YES NO

Development:
Are you reading to your child? .... YES NO
Does your child watch TV/tablet/phone/have other screen time? .... YES NO
(If yes, how much screen time per day? ______________________)
Do you have any concerns about your child's hearing or vision? .... YES NO
Any concerns about your child's development? .... YES NO

Does your child: (check all that apply)

☐ put objects into containers
☐ use 3-5 words
☐ scribble
☐ walk alone
☐ use a cup
☐ imitate chores
☐ point to 2 body parts
☐ bring books to you to read
☐ have interest in other children
☐ have interest in doll/stuffed animal
☐ throw objects in play
☐ understand simple commands

Social/Behavior:
If parent(s) work, who cares for your child? ____
Are there any family or social issues you would like to discuss? .... YES NO
Any concerns about your child's behavior (i.e. tantrums, hitting, biting)? .... YES NO
Is discipline (such as teaching, setting limits) a problem? .... YES NO

Safety/Preventative Health:
Do you brush your child's teeth? ☐ YES ☐ NO If yes, using fluoride toothpaste? ☐ YES ☐ NO
Have you scheduled a dental appointment for your child? .... YES NO
Is your home "child-proofed"? .... YES NO
Is your home/car a smoke-free environment? .... YES NO
Does your child use a rear-facing car seat 100% of the time? .... YES NO
*** A child should be rear-facing as long as possible, until they reach the highest weight or height allowed by their seat***

Do you have any questions/concerns about vaccines? .... YES NO
Any recent illnesses or fevers in the last 24 hours? .... YES NO
Does your child have any allergies (that you know of)? .... YES NO
Please list any medications or supplements you child took this week: ______________________________________