Patient ID_____ Patients Name_____

PCP_____ DOB_____

Today's Date_____

15 Month Old Parent Observations

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

_____

Feedings/Sleep:

Any concerns about feedings or weight gain?	Yes	No
Does your child eat well (i.e. has consistent appetite, not too picky)?	Yes	No

Your child's diet consists of: (check all that apply)

☐ Breastfeeding ☐ 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: (please check all that apply)

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

Social/Behavior:

If parents 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 <u>rear-facing</u> car seat 100% of the time?	Yes	No

Utah Law: A child should be rear-facing until age 2 years & 30 lbs

Do you have any questions/concerns about immunizations?	Yes	No
Any illness 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 your child took this week: _____

_____