Name: ____ Date of birth: ________________

Health Status Questionnaire – 15 Months

Baby lives with: mother father both parents other:____________________

Childcare: daycare babysitter stays at home other:________________________

Feedings:

__ cup __ bottle(should be weaned) __ formula __ breast __ solid foods

Formula/whole milk: <16oz/day 16-24oz/day 24-30oz/day >30oz/day

___ meals ___ snacks ___ grazes ___drinks water ___ oz juice/day

Any problems feeding? Y N ____

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N ____

Development concerns: none speech motor social cognitive vision hearing

Does your baby:

Walk well?	Y	N
Stoop down and stand back up?	Y	N
Climb or crawl up steps?	Y	N
Remove clothing?	Y	N
scribble?	Y	N
Dump items in a cup?	Y	N
Drink from cup?	Y	N
Tries to feed self?	Y	N
Say 3 words other than "mama" "dada"?	Y	N
Point to 1-3 body parts?	Y	N
Understand simple commands?	Y	N
immature babbling?	Y	N
Imitate some activities?	Y	N

Car seat use:	Y	N	Smoke detectors:	Y	N
Sunscreen:	Y	N	Fire extinguishers:	Y	N
Insect protection:	Y	N	Firearms/guns in house:	Y	N
Home child proofed:	Y	N	Locked away:	Y	N
Brush child's teeth:	Y	N	Passive smoke exposure:	Y	N

Do you have any concerns about your baby? ______________________________________

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Updated 8/28/17