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? _____

_____