California Pediatrics
Come grow with us

15 Month Well Exam

Name
Room
Notes

Weight	T
Length	HR
OFC	RR
	O2

Nutrition

What foods does your child eat?	Veggies	Fruit	Protein		
Does your child eat 3 meals per day?	Yes	No			
What type of milk does your child drink?	Whole	2%	1%	Breast	Formula
How much milk does your child drink?	12-16oz	<12oz	>16oz		

Dental

Do you brush your child's teeth?	Yes	No
Has your child seen a dentist yet?	Yes	No
Does your child drink from a bottle?	No	Yes

Sleep

Does your child sleep through the night?	Yes	No
How many naps does your child take per day?	2 or more	<2

Development

Do you feel that your child sees well?	Yes	No
Do you feel that your child hears well?	Yes	No
Does your child say at least 3 words other than mama, dada?	Yes	No
Can your child scribble?	Yes	No
Does your child walk well and climb furniture?	Yes	No
Does your child show imagination (playing with dolls/cars/phone)?	Yes	No
Do you read to your child?	Yes	No

Safety

Have you babyproofed your home?	Yes	No
Do you have the number to Poison Control?	Yes	No
Do you use a rear-facing carseat for your child?	Yes	No
Any smokers at home?	No	Yes

Risk Assessment

Has your child traveled outside of the U.S. in the last 6 months?	No	Yes
Exposure to anyone with a positive TB skin test?	No	Yes
Does your child live in or visit a home built before 1978?	No	Yes
Does your child live in or visit a home with chipping paint?	No	Yes

Followup D/W/M
Reason:

□EHR