KAISER PERMANENTE®

Well-Visit Questionnaire
Children Age 15 Months

Your child is 15 months old!

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your child for their well visit. At this visit, we will cover many important topics to support your child's growth, development, wellness, and safety, and we'll give your child any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your child.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
☐ Well Visit ☐ Allergies ☐ Cold/flu ☐ Constipation ☐ Cough ☐ Development ☐ Earache ☐ Fever ☐ Growth/nutrition ☐ Injury ☐ Rash ☐ Red eyes ☐ Sore throat ☐ Speech ☐ Temper ☐ Vaccines ☐ Vomiting ☐ Other (please explain):_____ Briefly describe your concern:_____	
Health Changes	
Has your child received any specialty or emergency care since the last visit? If Yes, please describe: _____	☐ Yes ☐ No
Has your child or anyone in the family developed a new health condition or died? Include parents, brothers, sisters, grandparents, aunts, uncles or cousins. If Yes, please describe: _____	☐ Yes ☐ No
Nutrition, Feeding and Supplements – Tell us about what your child eats.	
My child eats 3 meals and at least 1 snack each day:	☐ Yes ☐ No
My child eats a variety of fruits and/or vegetables over the course of a week:	☐ Yes ☐ No
My child eats iron-rich foods, like finely cut/ground meat, beans, iron-fortified cereal:	☐ Yes ☐ No
My child feeds themselves:	☐ Yes ☐ No
My child still drinks from bottles:	☐ Yes ☐ No
My child drinks more that 20 ounces of formula or whole milk per day:	☐ Yes ☐ No
Are you worried that your child is often constipated or having diarrhea?	☐ Yes ☐ No
Please list any other vitamins, supplements, or over-the-counter medicines you give your child: _____	
Dental Health	
Do you clean your child's teeth every day?	☐ Yes ☐ No
Has your child seen a dentist?	☐ Yes ☐ No
Does your water source have fluoride?	☐ Yes ☐ No ☐ I don't know
Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.	
My child:	
Understands most of what is said around them:	☐ Yes ☐ No
Says more than 3 words:	☐ Yes ☐ No
Imitates daily behaviors, like talking on a phone or wiping a table:	☐ Yes ☐ No
Follows simple directions:	☐ Yes ☐ No

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Squats to pick up items from the floor:	☐ Yes ☐ No
Crawls up stairs:	☐ Yes ☐ No
Walks on their own:	☐ Yes ☐ No
Tries to use utensils for feeding themselves, or tries to scribble:	☐ Yes ☐ No
Do you read to your child daily?	☐ Yes ☐ No
Vision	
My child's eyes track together and do not cross or wander:	☐ Yes ☐ No
Sleep	
My child sleeps through the night:	☐ Yes ☐ No
My child has a nap schedule and sleep routine:	☐ Yes ☐ No
My child is usually easy to put to sleep:	☐ Yes ☐ No
Safety	
My child rides in a rear-facing car seat in the back seat of the car for every car ride:	☐ Yes ☐ No
We have gates across stairs and safety guards on windows:	☐ Yes ☐ No
We have cleaning supplies, medicines, and matches locked away:	☐ Yes ☐ No
My child is always watched closely when they are in or around water (bathtubs, pools, ponds, buckets):	☐ Yes ☐ No
The buildings where my child lives or regularly visits were built after 1978 or, if built before 1978, have not been renovated in the past 6 months and do not have peeling paint:	☐ Yes ☐ No
We avoid giving my child choking hazards, like hard, round, or sticky food, balloons, small toys or other objects:	☐ Yes ☐ No
Our furniture is bolted to the wall to prevent tipping:	☐ Yes ☐ No
Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	☐ Yes ☐ No
What is your plan for childcare? ☐ Home with parent ☐ Family member ☐ Nanny or Sitter ☐ Childcare center	
Do you need assistance finding affordable and safe childcare?	☐ Yes ☐ No
Does your child watch TV or movies, or play games on a phone or tablet?	☐ Yes ☐ No
Is there anyone who lives in your home or cares for your child who:	
- Smokes or vapes tobacco or marijuana:	☐ Yes ☐ No
- Uses prescription pain medication:	☐ Yes ☐ No
- Uses other drugs:	☐ Yes ☐ No
- Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	☐ Yes ☐ No
Within the past 12 months, have you:	
- Run out of food or been worried your food would run out before there was money to buy more?	☐ Yes ☐ No
- Worried about housing or had to move?	☐ Yes ☐ No
- Had difficulty getting other supplies and services you need to care for your child? Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	☐ Yes ☐ No

NOT TO BE FILED IN THE MEDICAL RECORD

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