Reedsburg
AREA MEDICAL CENTER
Physicians Group

1900 N Dewey Ave. • Reedsburg Wisconsin 53959
Phone: (608) 524-6477 • Appt: (608) 524-8611 • Fax: (608) 524-8305
www.ramchealth.com

Patient Questionnaire – 15 Month Well Child

Patient Name:____ Date of Birth:___/___/___ Date:__________________

History Provided By (please circle)	Mother	Stepparent	Grandmother	Aunt		
	Father	Brother	Grandfather	Foster Parent		
	Legal Guardian	Sister	Uncle	Caseworker		
Lives With (please circle)	Mother	Stepparent	Grandmother	Aunt		
	Father	Brother	Grandfather	Foster Parent		
	Legal Guardian	Sister	Uncle	Caseworker		
Interval Problems (please circle)	Caregiver depression	Lack of social support	Recent illness			
	Caregiver stress	Marital discord	Recent injury			
	Chronic caregiver stress at home					
Nutrition						
Types of intake (please circle)	Breastfeeding	Eggs	Fruits	Meats	Cereals	Fish
	Juices	Vegetables	Cow's milk	Formula	Junk food	
	Non-nutritional					
	Milk/Formula intake volume oz/day: ____________					
	Meals per day: ____________					
Dental						
Has dental home (please circle)	Yes	No				
Elimination						
Elimination Problems (please circle)	Diarrhea	Urinary Symptoms	Constipation	Gas		

Please see reverse side

Behavior	
Behavioral Issues (please circle)	Stubbornness Throwing tantrums Waking up at night
Disciplinary Methods (please circle)	Consistency among caregivers Praising good behavior Spanking Ignoring tantrums Scolding Time outs

Sleep	
Sleep Location (please circle)	Crib Parent's Bed
How child falls asleep (please circle)	Bottle is in crib In caretakers arms while feeding On own In caretaker's arms **Average sleep duration in hours: ____________**

Safety/Environment	
Home is child-proofed (please circle)	Yes No Partially
Smoking in home (please circle)	Yes No
Working smoke alarms (please circle)	Yes No Don't know
Working CO (carbon monoxide) alarms (please circle)	Yes No Don't know
Car seat (please circle)	Yes No

Screening			
Immunizations up-to-date (please circle)	Yes No	**Risk factors for tuberculosis** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes No	**Risk factors for oral health** (please circle)	Yes No
Risk factors for anemia (please circle)	Yes No		

Social	
Caregiver enjoys child (please circle)	Yes No
Childcare location (please circle)	Child's home Daycare Another residence
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider
Days per week at daycare: ______________ **Hours per day at daycare:** ______________	
Sibling interactions (please circle)	Fair Good Poor

Growth and Development

Do you or your family/childcare provider have concerns about your child's speech, learning, motor skills or behavior? (please circle)

Yes No

Does your child:

Have behavior that makes you concerned? (please circle)

Yes No

Make you concerned due to an absence of speech or social skills? (please circle)

Yes No

Look you in your eyes for more than a second or two? (please circle)

Yes No

Point or gesture for what he/she wants (for example an object or toy)? (please circle)

Yes No

Interact with family? (please circle)

Yes No

Follow simple commands such as "stop" or "give me"? ? (please circle)

Yes No

Please see reverse side

Growth and Development Cont.

Does your child:

Say at least one word besides "mama" or "dada"? (please circle)

Yes No

Imitate what you do? (please circle)

Yes No

Walk well without help? (please circle)

Yes No

Feed self? (please circle)

Yes No

Run? (please circle)

Yes No

Take steps backward? (please circle)

Yes No