15 Month Health Maintenance Form

Patient Name _____

Who accompanied child today?
(name and relationship to child) _____

Who does child live with? _____

Any Chronic health problems? _____

Concerns about the above health problems? _____

New or recent health concerns? _____

Feedings:
What type of milk is your baby getting? _____

Method of milk feeding? Cup Breast Bottle

Tolerating most Table Foods? Yes No

Any concerns with stooling or urination? _____

Sleep pattern:
Average hours of nighttime sleep: _____

Number of naps: _____

Length of naps: _____

Are there any smokers in the household? _____

Medications:
Please list current medications: _____

_____

_____

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Any allergies to medicine? _____

_____

Does your child:

Walk well alone?	Yes	No
Stoop to recover objects from floor?	Yes	No
Walk backwards?	Yes	No
Drink from a cup?	Yes	No
Use 1-3 word vocabulary	Yes	No
Understand simple directions?	Yes	No
Put a block or other object in a cup?	Yes	No
Wave bye-bye?	Yes	No
Hug parents, beginning to pucker and kiss?	Yes	No

How many children's board books do you have at home?

1. 0
2. 1-6
3. More than 6

In a week, how many times do you read or look at books with your child?

1. 0
2. 1-3
3. 3-5
4. Almost every day

If you do not understand any of these questions, please ask your nurse.