# Your Child's 15 Month Well Visit – What to Expect, What to Ask

Your Name: _____ Your Relationship to the Child: _____
Are there specific concerns you want to discuss today? □ No □ Yes _____

Have there been any major changes in your family lately? □ None □ Move □ Job Change □ Separation □ Divorce
□ Death in the family □ New pet □ Other? Describe: _____

Child lives with? □ Both Parents □ Mother □ Father □ Stepparent □ Grandparent(s) □ Other? _____
Total number of adults living in home: _____ Total number of children living in home: _____

Who takes care of your child most days of the week?
□ Mother □ Father □ Other relative (e.g. grandmother) □ Daycare □ Other? Describe: _____

In general, how well do you feel you are coping with the day-to-day demands of parenthood?
□ Not well at all □ Not very well □ Somewhat well □ Well □ Very well

| **General Health Information:** Since Your Last Visit | Yes | No | Unsure |
|---|---|---|---|
| Have you or your child had any major illness and/or hospitalizations? | | | |
| Have you, anyone in your family, or your child's relatives developed new medical problems? | | | |
| Does your child have allergies? If yes, describe: | | | |
| Does your child take medications regularly? If yes, list here: | | | |
| Do you have someone you can trust and go to for emotional support? | | | |
| Are yours and your child's immunizations (includes flu and pneumonia vaccines) current? | | | |
| Do you or any adults around your child smoke (includes inside or outside the house)? | | | |

**Would you like to get more information on any of the topics below?**

| **Injury Prevention** | **Health Promotion** | **Behavior** | **Nutrition** |
|---|---|---|---|
| • Car safety restraints | • Immunizations | • Parent/infant interaction | • Healthy diet/snacks |
| • Choking, unsafe toys | • Smoking in home | • Social interaction | • Iron-rich foods |
| • Poison control | • Well-child care | • Limit TV | • Physical activity |
| • Burns/electrical safety | • Dental care, appointment | • Discipline strategies | • Weaning off bottle |
| • Water safety/temp | • Family Planning | • Sibling rivalry | |
| • Supervised play | • Daycare | • Toilet training | |

Do you have any specific concerns about your child's learning, development or behavior? □ A lot □ A little □ Not at all
Describe: _____

Do you have any concerns about your child's vision (how well your child sees)? □ Yes □ No

Do you have any concerns about your child's hearing? □Yes □ No

**Please check each task your child is able to do right now:**
□ Walking □ Drinks from a cup □ Speak one word (not including Mama/Dada) □ Puts blocks in a cup □ Bend down without falling

**What to expect at your Child's Texas Health STEPS exam:**
□ Length □ Weight □ Lab tests – lead questions □ Unclothed Physical Exam & Health History
□ Head Circumference □ Parent Hearing Checklist □ Immunizations (Hib, Pneumococcal, MMR, Varicella, Hepatitis A, DTaP)

*This is not a self-diagnosis tool or a treatment plan. Please consult your doctor and share this form at your next visit.*