MUNDELEIN PEDIATRICS

15 Month Well Exam

Name: _____DOB: ____/____/____ Today's Date: ____/____/____

Please circle the answer that most appropriately describes your child:

1. Sleeps through the night: Yes/No Concerns: _____
   (____) hours per night
   (____) hours from naps during the day
2. Good eating habits: Yes/No Concerns: _____
   Milk: (____) ounces of milk daily
   Fruit juice: (____) ounces of fruit juice daily
3. Urinating well: Yes/No Concerns: _____
4. Normal bowel movements: Yes/No Concerns: _____
5. Rides in a rear-facing car seat in the back seat: Yes/No Concerns: _____
6. Takes Vitamins: Yes/No Product Name: _____
7. Emergency room visits: Yes/No
8. Illness since last visit: _____
9. Developmentally: drinks from a sippy cup, thumb-finger grasp, imitate sounds, indicate individual wants (not crying), understands no, follow directions (2 out of three times), three words other than mama/dada, walks well, walks up steps with help, draws line with crayon, builds a tower of 3 cubes

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Please circle the answer that most appropriately describes your home environment:

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Firearms at home: Yes/No If yes; are safety precautions taken: Yes/No
4. Television/Video game time Yes/No Hours per day: _____
5. Daycare: None/Relative/Center/Babysitter
6. Primary care taker: Mom/Dad/Grandparents
7. Household composition:
   Adult(Names/Ages): _____
   Children(Names/Ages): _____
8. New health problems in parents or siblings: _____
9. Past vaccine reactions: Yes/No
10. Sibling rivalry: Yes/No

Do you have any other concerns you wish to discuss? Yes/No

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