NOVANT HEALTH

Appt Date 15 month Check Up

Patient Name_______________________________________DOB__________________________

Name of person filling out form________________________ Phone number_________________

Nutrition:

What does your child drink? (circle all that apply) Formula Breast Milk Whole Milk Soy Milk

How many ounces of milk does your child drink per day? ____

How many ounces of juice does your child drink per day?____

How many ounces of water does your child drink per day?____

Does your child eat a variety of meats, fruits, and vegetables each day?____________________________________

Bowel/Bladder:

Any concerns about your child's voiding or stooling?____

Sleep:

How many hours does your child sleep at night? ____

How many naps does your child take during the day? _____________ How long are the naps? _______________

Hearing/ Vision:

Any concerns about your child's hearing or vision?____

Social hx:

Does your child attend daycare, preschool, or stay at home?____

How much screen time does your child get each day? ____

Development

Please check the following developmental milestones your child has accomplished:

___Drinks from cup; no bottle

___Starting to use a spoon

___Walks independently

___Stoops and recovers

___Has temper tantrums

___Throws ball underhand

___Stacks two objects

___Four to six words other than mama, dada

___Indicates wants or needs

___Responds to one-step commands

Advice and Guidance for Parents: *(please check off as you read)*

___Accidents are the main cause of injury, be careful around pools, things that cause burns, choking hazards

___Fluoride supplement is needed unless you have city water or fluorinated bottled water

___ Nutrition: Your child may become a picky eater. This is ok as long as he/she gets some meat, fruits, and veggies 3 to 5 days a week. Limit milk to 12 to 20 oz. daily.

___Wear SPF 30 or greater for sun exposure

___Read to your child at least once every day

___"Catch" your child being good

___Smoke Exposure: Minimize your child's exposure to cigarette smoke

___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____

___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___

___You should brush your child's teeth every night, twice a day if possible (this is "non-negotiable")

___ Sleep: Your child should have 14 hours of sleep per day (1-2 naps a day and sleep all night in own room)

___ Behavior: put in time out for one minute for major offenses like biting or hitting

(for podcasts on Sleep and Behavior, go to www.shotshurtless.com)

PEDS Response Form

Provider ______

Child's Name ______ *Parent's Name* ______

Child's Birthday ______ *Child's Age* ______ *Today's Date* ______

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.

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