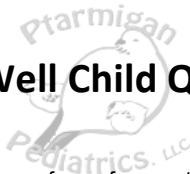


Office Use Only

VFC: [] MDD/DKC
[] Native
[] NO Insurance
[] Not Eligible

INSURANCE Notes

18 Month Well Child Questionnaire



Office Use Only

WT: _____ kg _____ lb
Length: _____
OFC: _____

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. *If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.*

Child's Name: _____

Birth Date: _____

Do you have any concerns about your child today? _____

Is your child on any medicine? Yes / No. Which ones/dose? _____

Any allergies to medicines, foods, latex, etc.? Yes / No. Which ones? _____

Has your child had any difficulty with past immunizations? Yes / No. If yes, which ones? _____

Has your child had any surgeries? Yes / No. If yes, describe: _____

Has your child been hospitalized overnight? Yes / No. Is yes, why: _____

Health

Is your child exhibiting any of the following symptoms?

Ear Pain / Ear Pulling	Yes / No. If yes, how long? _____	Fever	Yes / No. If yes, how long _____
Headache	Yes / No. If yes, how long? _____	Neck Pain	Yes / No. If yes, how long _____
Chest Pain	Yes / No. If yes, how long? _____	Cough	Yes / No. If yes, how long _____
Decreased Appetite	Yes / No. If yes, how long? _____	Vomiting	Yes / No. If yes, how long _____
Abdominal Pain	Yes / No. If yes, how long? _____	Diarrhea	Yes / No. If yes, how long _____
Urinary Symptoms	Yes / No. If yes, how long? _____	Rash	Yes / No. If yes, how long _____
Sleep Problems	Yes / No. If yes, how long? _____	Joint Pain	Yes / No. If yes, how long _____

Nutrition

Whole milk? Yes / No. Ounces per day: _____

If 8 oz milk, 8 oz yogurt, or 1½ oz cheese equal 1 serving of dairy, how many total servings of dairy does your child consume each day? _____

Is your child still breastfeeding? Yes / No. How many times per day? _____

Circle your child's water supply source: City Bottled Well.

Is your child on a cup AND off the bottle? Yes / No.

Can your child use an open cup? Yes / No. Does your child use a pacifier? Yes / No.

How many ounces of juice, soda and other sugar-sweetened beverages does your child consume each day? _____

Does your child eat a reasonable amount and variety of table foods? Yes / No.

Is your child on vitamins? Yes / No. Which brand? _____

Social

Any changes in your child's environment? (new home, pets, daycare, etc.) _____

Who lives in the household with you? _____

Who is the primary caretaker? _____ Is Mom working? Yes / No. Full time / Part Time

Does anyone in the family smoke? Yes / No. If yes, who? _____

Is your child in daycare? Yes / No. If yes, where? _____

Any pets? Yes / No. If yes, which kind? _____

Any food allergies in your family? Yes / No. If yes, who and to what? _____

Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____

Are there firearms in your home? Yes / No.

Sleep and Elimination

How many hours straight does your child sleep at night? _____

Does your child nap daily? Yes / No. If yes, how often and how long? _____

Does your child have any problems with urinating? Yes / No. Any problems with stooling? Yes / No.

This form completed by: _____ Relationship to Child: _____