16-22 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have any concerns about your child's health?	NO	YES
2	Has your child had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?	NO	YES

Feeding/Nutrition

4	Is your child breastfeeding?	NO	YES	Never breastfed
5	Is your child drinking formula or milk well?	YES	NO	
	a Which kind of milk or formula?			
6	Does your child eat fruits or vegetables at every meal?	YES	NO	
7	Do you feed your child mostly whole grains?	YES	NO	
8	Does your family eat junk foods (chips, cookies, crackers, candy) or fast foods?	NO	YES	
9	Do you keep away any foods that your child can choke on (raw vegetables, nuts, hot dogs, popcorn)?	YES	NO	
10	Does your child drink from a bottle?	NO	YES	
11	Does your child drink juice or other sweetened drinks?	NO	YES	
12	Do you give your child any vitamins or supplements?	NO	YES	
13	Are you worried about your child's weight?	NO	YES	

Oral Health

14 Are cavities a problem for you or anyone in your family?	NO	YES
15 Are you using a soft toothbrush with fluoridated toothpaste to clean your child's teeth 2 times per day?	YES	NO
16 Do you have a dentist for your child?	YES	NO
17 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

18 Does your child have any problems with bowel movements (pooping)?	NO	YES
19 Do you have any questions about toilet (potty) training?	NO	YES

Activity/Exercise/Screen time

20 Does your baby have screen time (smartphone, tablet, TV)?	NO	YES
21 Do you play with your child every day?	YES	NO
22 Do you read to your child every day?	YES	NO

Sleep

23 Does your child sleep through the night?	YES	NO
24 Do you have a bedtime routine?	YES	NO
25 Does your child fall asleep on his/her own, in his/her own bed?	YES	NO

Social Stressors

26 Do you feel that you receive the support you need?	YES	NO	
27 Have there been any major changes or stresses in your family recently?	NO	YES	
28 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
29 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
30 Do you have any worries or concerns about childcare?	NO	YES	

Behavior

31 Does your child have a lot of tantrums?	NO	YES
32 Do you have any questions about how to discipline your child?	NO	YES
33 Do you praise your child when he/she is behaving well?	YES	NO

Development (please refer to Ages and Stages Questionnaire)

Lead

34 Is your child regularly in a house built before 1978?	NO	YES
a Is there any peeling or chipping paint?	NO	YES
b Has there been any recent or ongoing remodeling or do you plan to do any remodeling?	NO	YES
35 Does your child have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

36 Is the crib mattress at the lowest position?	YES	NO
37 Does anyone smoke or vape around your child	NO	YES
38 Do you have working smoke detectors and carbon monoxide detectors in your home?	YES	NO
39 Do you keep plastic bags and balloons away from your child?	YES	NO
40 Does your child ride in a rear-facing safety seat, in the back seat?	YES	NO
41 Do you keep your child away from the stove?	YES	NO
42 Is there a swimming pool, pond, or lake near your home?	NO	YES
43 Do you have a fire escape plan?	YES	NO
44 Do you keep furniture away from windows or use window guards?	YES	NO
45 Do you have a gate on your stairs?	YES	NO
46 Do you have the number for Poison Control?	YES	NO

Review of Systems

47 Do you have any concerns about your child’s hearing?	NO	YES
48 Do you have any concerns about your child’s vision?	NO	YES