PEDIATRIC HEALTH MAINTENANCE – 18 Months

Parent Questionnaire

General

Do you have any concerns or questions you would like to discuss today?	☐ No	☐ Yes
If yes, please specify:		
Is your child in daycare or the care of someone outside of parents?	☐ No	☐ Yes
Do your child's eyes ever appear to cross or drift apart?	☐ No	☐ Yes

Feeding and Sleeping

What type of milk does your child drink?			How much?		
Are you giving your child any vitamins?	☐ No	☐ Vitamin D	☐ Iron	☐ Other	
Does your child eat a good variety of foods (meat/protein, vegetables, grains, fruit)?				☐ Yes	☐ No
Have you begun to brush your child's teeth?				☐ Yes	☐ No
What method does your child receive fluoride?	☐ Water	☐ Toothpaste	☐ Dentist/Varnish		
Does your child sleep through the night?				☐ Yes	☐ No
Does your child sleep with a bottle?				☐ No	☐ Yes

Development

Does your child point to show you something interesting?	☐ Yes	☐ No
Does your child try to say three or more words besides "mama' or "dada"?	☐ Yes	☐ No
Does your child follow one-step directions without any gestures like giving you the toy when you say, "give it to me"?	☐ Yes	☐ No
Does your child walk without holding on to anyone or anything?	☐ Yes	☐ No
Does your child feed themself with their fingers?	☐ Yes	☐ No
Does your child try to use a spoon?	☐ Yes	☐ No

Safety

Do you have safety caps on all medicines, vitamins, and herbal products?	☐ Yes	☐ No
Do you keep medicines, household cleaners, and sharp objects in locked drawers or cabinets?	☐ Yes	☐ No
If you have stairs, do you use a gate at the top and bottom of the stairway?	☐ Yes	☐ No
Do you know what to do if your child eats or drinks a poisonous substance?	☐ Yes	☐ No
Do you know what to do if your child is choking?	☐ Yes	☐ No
Do you give your child hard raw vegetables, hard candy, gum, nuts, or popcorn?	☐ No	☐ Yes
Do you leave your child alone in the bathtub?	☐ No	☐ Yes
Does your child play with latex balloons or plastic wrappers?	☐ No	☐ Yes
Do you have a firearm in your home?	☐ No	☐ Yes
If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them?	☐ Yes	☐ No
Are you afraid of your partner or anyone close to you?	☐ No	☐ Yes
Do you feel overly stressed or unsupported?	☐ No	☐ Yes

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME

VIRGINIA MASON FRANCISCAN HEALTH
Pediatric Health Maintenance – 18 Months

VMMC99181 (04-2025)