Medical Record Number

Patient Name

Patient Label

Well Baby Check: 9 month visit questionnaire

Interval History:

Has your baby had any major illnesses, ER or Urgent Care trips since your last appointment in the office?	No	Yes
Has your baby had any reactions to vaccinations in the past?	No	Yes

Development:

Can your baby feed him/herself finger foods?	Yes	No
Can he or she pick objects up with the tip of thumb and index finger?	Yes	No
Does your baby babble (e.g. "dada," "mama")?	Yes	No
Can your baby sit without support?	Yes	No
Does your baby crawl or scoot around?	Yes	No
Does your child pull him/herself up to stand?	Yes	No
Do you have any concerns about how your child sees?	No	Yes
Do your child's eyes appear unusual or seem to cross, drift or be lazy?	No	Yes
Do your child's eyelids droop or does one eyelid tend to close?	No	Yes
Do you have concerns about how your child hears?	No	Yes

Dental Health:

Does your child's primary water source contain fluoride?	Yes	No	Unsure
If no, does your child take a fluoride supplement?	Yes	No	N/A
Does your child sleep with a bottle?	No	Yes	
Does your child continuously breastfeed throughout the night?	No	Yes	

Staying Healthy/Safety/Tobacco Exposure:

Does your baby watch TV?	No	Yes	
Does your home have a working smoke detector?	Yes	No	
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	N/A
If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	N/A
Does your home have cleaning supplies/medicines/matches locked away?	Yes	No	
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	

Do you always put your baby to sleep on her/his back?	Yes	No	
Do you always stay with your baby when she/he is in the bathtub?	Yes	No	
Do you and your baby spend time near water (pool, river or lake)?	No	Yes	
If so, is your baby always safely supervised?	Yes	No	N/A
Do you use sunscreen when your child is outdoors?	Yes	No	
Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	
Is your car seat the right one for the age and size of your baby?	Yes	No	
Does your baby spend time in a home where a gun is kept?	No	Yes	Skip
If so, are all guns safely stored in a gun safe or locked with ammunition separate from gun?	Yes	No	N/A
Does your baby spend time with anyone who smokes?	No	Yes	

Risk Assessment for Lead Exposure:

Does your child live in or regularly visit a house or child care facility built before 1950?	No	Yes
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?	No	Yes
Does your child have a sibling or playmate who has or did have lead poisoning?	No	Yes
Does your child take any imported remedies or supplements?	No	Yes

Sleep:

How many hours does your baby sleep at night?	_____hours
How many hours does your baby nap throughout the day?	_____hours
Does your baby sleep through the night without feeding?	Yes No

Nutrition/Physical Activity:

For Breastfeeding: How many minutes of feeding per side?	_____minutes
For formula/bottle feeding: How many ounces per feeding?	_____oz
If you are giving formula, what brand are you using?	_____
How often does your baby feed?	Every_____hours
How many feedings of breast milk/formula in 24 hours?	_____feedings
How much juice does your child drink in 24 hours?	_____oz
Is your child eating fruits and vegetables well?	Yes No

Does your baby drink or eat 3 servings of calcium-rich foods daily,
such as formula, breast milk, cheese, yogurt, or tofu? Yes No

Does your child eat meat (such as chicken, fish, beef or pork)? Yes No

Do you offer your child a sippy cup every day? Yes No

Do you give your baby a bottle of anything except breastmilk, formula,
milk or water? No Yes

Do you have any concerns about your baby's feeding? No Yes

Elimination:

Does your baby have bowel movements on a regular basis with
a normal (soft) consistency? Yes No

Please list any medications or supplements your baby is taking, including vitamin D:

_____

Who lives in the home with your baby? _____

Who provides daytime care for your child? _____

Please list any major family medical issues: _____

Please list any known allergies to medicine: _____

Please list any known food allergies: _____

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

_____

Parent or Guardian Signature: _____

Date: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date: