Patient Name

Date of Birth

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: