**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
### Questionnaire ● Well Baby Check 9 Month

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

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<tr>
<th>Clinic Use Only</th>
<th>Counseled</th>
<th>Referred</th>
<th>Anticipatory Guidance</th>
<th>Follow-up Ordered</th>
<th>Comments:</th>
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<tbody>
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<td>Nutrition</td>
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<td>Tobacco Exposure</td>
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<td>Dental Health</td>
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PCP's Signature: Print Name: Date: 

[Patient Declined the SHA]