



Patient Name:

Date of Birth:

Well Baby Check: 9 month visit questionnaire

Interval History:

Has your baby had any major illnesses or doctor visits since last seen here? No Yes
 Has your baby had any reactions to vaccinations in the past? No Yes

Development: Can your baby (check all that apply) -

- | | |
|---|---|
| <input type="checkbox"/> feed him/herself finger foods? | <input type="checkbox"/> sit without support? |
| <input type="checkbox"/> pick objects up with thumb and index finger? | <input type="checkbox"/> crawl or scoot around? |
| <input type="checkbox"/> babble (e.g. "dada," "mama")? | <input type="checkbox"/> pull to stand? |
| <input type="checkbox"/> understand "no" or their name? | <input type="checkbox"/> see without crossing/drifted eyes? |

Who provides daytime care for your child? _____

Nutrition/Elimination:

For Breastfeeding: _____ minutes per side every _____ hours

For bottle feeding: _____ ounces every _____ hours of [breastmilk] [formula _____]

Does your baby drink anything except breastmilk, formula, or water? No Yes
 Do you offer your child a sippy cup every day? Yes No
 Is your child eating fruits and vegetables well? Yes No
 Does your baby eat iron-rich foods (meat, iron-fortified cereal, beans) daily? Yes No
 Does your baby have daily poops with a soft/loose consistency? Yes No

Baby's medications/vitamins/supplements: _____

Mother's medications/vitamins/supplements if giving breastmilk: _____

Dental Health:

Does your child sleep with a bottle or breastfeed throughout the night? No Yes

Sleep:

What is the longest time your baby sleeps at night without feeding? _____ hours

How many hours does your baby nap throughout the day? _____ hours

Can your baby self-soothe? Yes No

Where does your baby sleep? _____

Staying Healthy/Safety:

Does your baby get any screen time? No Yes
 Does your home have a working smoke detector? Yes No
 Is your water temperature set to less than 120 degrees? Yes No N/A
 Is your baby always supervised when near water, including the bathtub? Yes No
 Have you child-proofed your home? Yes No
 Do you have safety guards on upper floor windows and gates for stairs? Yes No N/A
 Does your home have cleaning supplies/medicines/matches locked away? Yes No
 Is the Poison Control Center number (800-222-1222) posted by/in your phone? Yes No
 Does your baby use a walker? No Yes

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Does your child use sun protection when outdoors?	Yes	No	
Is your car seat appropriately sized, rear-facing, and in the back seat?	Yes	No	
Are all guns 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 or vapes?	No	Yes	

Please list any new major family medical issues:

Who lives in the home with your child?

What international travel has your child had since their last well check? (where and how long)

What plans are there for international travel with your child in the next 12 months? (where and how long)

What concerns would you like to discuss today?
