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) -

☐feed him/herself finger foods?
☐pick objects up with thumb and index finger?
☐babble (e.g. "dada," "mama")?
☐understand "no" or their name?
☐sit without support?
☐crawl or scoot around?
☐pull to stand?
☐see without crossing/drifting 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☐

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?

_____