9 Month Visit Questionnaire

Today’s Date: ___________ Patient Name: ________________________________ Sex: M / F  DOB: ________________

Your Growing and Developing Baby

What would you like to discuss Most today?
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Is your infant taking medications  □ NO  □ YES, list ________________________________

Childcare  □ NO  □ YES, Name__________________________  Recent ER/Urgent Care Visit □ NO □ YES ____________

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? □ NO □ YES ____________

I have other concerns/questions about my baby: □ No □ Yes (check all that apply) □ Crying with new people
□ Vision □ Hearing □ Development □ Growth (weight, length, head size) □ Child Proofing home
□ Increasing solids/table food □ Stooling Habits □ Food Allergies □ Car Safety (When to turn the Car-seat around)
□ Water & Sun Safety □ Dental Care □ Using a cup □ Sleep Habits □ Unusual Behaviors

Explain in detail/other ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have there been recent major changes in your family? □ NO □ YES ____________
□ move □ job change □ separation □ divorce □ death in the family □ other __________________________

NUTRITION & GENERAL HEALTH (Select all that apply)

Supplements: □ Vitamin D □ Multivitamin/Iron
Water Source: □ No Water □ Well □ Tap (city _________) □ Filtered Tap □ Bottled □ Nursery Water w/Fluoride

□ Breast milk # of Feedings per day _________ AND/OR # of ounces of pumped breastmilk per day _________
□ Formula Type:_____________________________ ounces per day: _________
□ Juice ounces per day _________
□ Solid Foods □ purees □ cereals □ meats □ fruits □ vegetables □ yogurt/cheese □ table foods

Elimination: Stools at least once daily: YES or NO □ Voids several times a day: YES or NO
Sleep: Takes Naps: YES or NO Longest stretch of sleep at night _____ hrs

Check off each of the tasks that your baby is able to do:

□ look for something that has been dropped □ pull to a stand □ afraid of new people □ go to you to play □ crawls
□ go to you to point things out □ sit well □ can repeat sounds □ look at books □ play peek-a-boo

Completed By ___________________________________________ Relationship to Patient_______________

Reviewed by Physician:_______________________________________ Date: _____________________________
9 Month Well Visit

Name ____________________________________________________________ M T W Th F Date __________________ Time: ______

Date of Birth ____________________ Age ________ Sex: M / F Allergies: ____________________________________________

Accompanied by: MOM / DAD / OTHER ____________________________

--------------------------------------------------------------- CLINICAL STAFF USE ONLY BELOW THIS LINE -----------------------------------------------

HISTORY: 9 mo SWYC: Reviewed, Discussed and Results: □ NORMAL □ ABNORMAL
□ Past Medical History Reviewed □ Medications Reviewed & Updated □ Child has special healthcare needs

Interval History (Illnesses, Changes): □ None □ Specify: ____________________________

Concerns & Questions: □ None □ Addressed: __________________________

Growth Measurements: WEIGHT: _____ lbs _____ oz _____ % LENGTH: _____ inches _____ % HC: _____ inches _____ %

Vitals: Temp _________ Pulse _________ Resp _________

Triaged by: ____________________________ RN/ LPN

Physical Examination: □ NL in its entirety including:
□ General appearance □ Head □ Eyes ( Red Reflex □ OD □ OS ) □ Ears □ Nose / Mouth / Throat □ Lungs □ CV □ Abdomen
□ Genitourinary □ Musculoskeletal / Extremities □ Hips □ Reflexes □ Back □ Skin □ Neurological

Remarks:

____________________________________________________________________________________

____________________________________________________________________________________

ASSESSMENT: Well Child

Development normal for age? □ yes □ borderline □ no ____________

Behavior normal for age? □ yes □ no ____________________________

Growth is normal for age? □ yes □ no ____________________________

____________________________________________________________________________________

____________________________________________________________________________________

Anticipatory Guidance: □ Discussed

□ Infant Independence □ Family adaptations □ Feeding routine □ Safety □ Oral Health

Consistent routines □ Limit the word “no” □ Self feeding □ Car safety seat □ Brush teeth

Separation anxiety □ Age-appropriate discipline □ Solid foods □ Falls/ window guards □ Avoid bottle in bed

Learning & developing □ Domestic violence □ Safe foods □ Poisons

No TV (screen time) □ Time for self/partner □ Using a cup □ Water/ drowning

Breastfeeding (Vit D; Iron; Burns) □ Guns

Lab forms or Questionnaires may be attached

PLAN: Immunizations: □ Up to Date, Provided: ____________________________

□ Vaccine Information Sheet(s) given □ Vaccine risks & benefits discussed

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

LABS: □ NO □ YES

SCHOOL FORMS: □ YES □ NO

FOLLOW UP/NEXT VISIT ____________________________

Physician Signature ____________________________ Date ____________________________