UW Medicine
UW NEIGHBORHOOD CLINICS

Nine Month Old Well Child Visit

Baby's Name_____ Age _____Date:_____

Person completing the form:_____Relationship to the patient:_____

Has your child had any illnesses, hospitalizations or surgeries since last visit? (YES) or (NO)

Review ofNutrition:	Yes	No	
Is your baby feeding well?	( )	( )	
Is your baby breast fed? if yes, how often?	( )	( )	
Is your baby formula fed? If yes what formula?	( )	( )	
How many ounces per feeding? and how often?	( )	( )	
Is your baby starting to eat foods that need to be chewed?	( )	( )	

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:	Yes	No
Is your child expose to TV or videos?	( )	( )
Does your child always ride in a car seat, in the back seat, facing backwards?	( )	( )
Do you or anyone who cares for your child, or anyone in the home smoke?	( )	( )
Does a family member work with lead (car batteries, making stained glass, lead solders etc)?	( )	( )
Do you live in a house built before 1978?	( )	( )

Oral Health:	Yes	Yes
Have you found a dentist for your child yet?	( )	( )

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	( )	( )
Does your child sleep well, without snoring?	( )	( )
Do you have any concerns about your child's learning, development or behavior?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
Do you need assistant enrolling your child in daycare?	( )	( )