9-Month-Old Well Child Visit

Baby's Name: _____ Baby's Age: _____ Date: _____

Person completing the form _____ Relationship to the patient _____

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

Nutrition:	**Yes**	**No**
Is your baby feeding well?	☐	☐
Is your baby breastfed?	☐	☐
• If yes, how often? _____		
Is your baby formula fed? If yes:	☐	☐
• What formula? _____		
• How many ounces per feeding? _____		
• 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**
How many hours of TV or video is your child exposed to per day? _____	☐	☐
Does your child always ride in a car seat, in the back seat, facing backwards?	☐	☐
Do you, anyone in your home, or anyone who cares for your child smoke?	☐	☐
Do any family members work with lead (car batteries, stained glass, lead solders, etc.)?	☐	☐
Do you live in a house built before 1978?	☐	☐

Oral Health:	**Yes**	**No**
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 how your child is learning, developing and behaving?	☐	☐
Are you interested in enrolling your child in daycare?	☐	☐
• If yes, do you need assistance to find a suitable program?	☐	☐

PLACE PATIENT LABEL HERE