Pediatric Health Maintenance: 9 Months
Parent Questionnaire

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health		☐ I'd like to discuss
☐ Yes	☐ No	Concerns about your baby's vision?
☐ Yes	☐ No	Concerns about your baby's hearing?
☐ Yes	☐ No	Do his /her eyes appear to cross or drift apart?
☐ Yes	☐ No	Is your baby in childcare?

Feeding and Sleeping		☐ I'd like to discuss
What is your baby fed?		☐ Breastmilk ☐ Formula (type): ☐ Solids (frequency):
Any vitamins?		☐ Vit D ☐ Iron ☐ Other:
☐ Yes	☐ No	Is there fluoride in your water? ☐ Don't Know
☐ Yes	☐ No	Do you think your baby's bowel movements are normal?
☐ Yes	☐ No	Does your baby sleep through the night?

Development		☐ I'd like to discuss
☐ Yes	☐ No	Can your child sit well unsupported?
☐ Yes	☐ No	Can your child pull himself up to a standing position if holding onto something?
☐ Yes	☐ No	Can your child get up on his or her hands and knees?
☐ Yes	☐ No	Can your child pick up a small object like a Cheerio between the thumb and pointer finger?
☐ Yes	☐ No	Does your child babble and imitate sounds?

Safety		☐ I'd like to discuss
☐ Yes	☐ No	Are small objects kept out of baby's reach at all times (e.g. coins, siblings' small toys, peanuts)?
☐ Yes	☐ No	Have you baby-proofed your home?
☐ Yes	☐ No	Does your child ride in a rear-facing car seat, in the back seat?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/ Questions for Visit

☐ By typing my name in the box below, I understand that I am providing a binding electronic signature to the Well Visit 9 Months form.

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME & ID #