9 Month Well Child Check Name_____

Allergies_____Current Meds_____

Is your baby healthy?	**Yes**	**No**_____
Do you feel your baby is developing normally?	Yes	No_____
Has your baby had any injuries?	No	Yes_____
Does your baby stool daily?	Yes	No_____
Does your baby sleep at least a 4-6 hour stretch at night?	Yes	No_____
If breastfeeding—are you having any problems?	**No**	**Yes_____**
How often is your baby nursing?		_____
If formula feeding—Type of formula?		_____
How many ounces/how often?		_____
Does your baby eat a variety of solids?	Yes	No_____
Does your baby eat finger foods?	Yes	No
Is your baby having any feeding problems?	**No**	**Yes**_____
Is there Fluoride in your drinking water? (city water=yes)	Yes	No
Has there been any recent change to your family structure?	No	Yes_____
Does anyone in your household smoke?	No	Yes
Is your baby in childcare?	No	Yes_____
Does your baby take naps?	*Yes*	*No*_____
Does your baby eat a combination of table foods and baby foods?	*Yes*	*No*_____
Does your baby drink juice? If so, how many oz/day?	*No*	*Yes*_____

*Do you have any other concerns?*_____

Lead Screening

1. Does your child live in or regularly visit a home or apartment built before 1950? No Yes
2. Does your child live in or regularly visit a home or apartment that is being remodeled that was built before 1978? No Yes
3. Is there an adult in the home whose job or hobby exposes them to lead? (Examples: construction, painting, radiator repair, fishing, pottery, stained glass) No Yes
4. Does your child have a brother, or sister or friend who has a history of lead-poisoning? No Yes
5. Has your child been given any home remedies that may contain lead? Examples: azarcon, rueda, coral, Maria Luisa, alarcon, liga, albayalde, greta, pay-loo-ah, ghasard, bala goli, kandu or kohl) No Yes

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Development (Do not complete if given Ages and Stages Questionnaire)

Does your baby babble or imitate sounds?	Yes	No
Does your baby say mama or dada?	Yes	No
Does your baby respond to his/her name?	Yes	No
Does your baby understand No?	Yes	No
Does your baby creep, crawl or scoot?	Yes	No
Does your baby sit independently?	Yes	No
Does your baby pull him/herself to a stand?	Yes	No
Does your baby use his/her index and thumb to pick up small objects?	Yes	No
Does your baby transfer small blocks from hand to hand?	Yes	No
Does your baby look for fallen objects?	Yes	No
Does your baby shake, bang or throw objects?	Yes	No
Does your baby play peek-a-boo?	Yes	No
Does your baby have stranger anxiety?	No	Yes
Has your baby started to use a sippy cup?	Yes	No
Does your baby usually sleep through the night?	Yes	No
