

Well-check questionnaire

9 month well-check

Patient name: _____ **DOB:** _____ **Today's date:** _____

Medications: _____ **Allergies:** _____

Mother's maiden name: _____

Are you breast or formula feeding? _____

Name of formula: _____ Ounces per feeding: _____

Of wet diapers a day: _____ # Of stools a day: _____

- | | | |
|--|-----------------------------|------------------------------|
| Do you have any concerns with feedings? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your baby eat a combination of table and baby food? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have you introduced meats and/or baby food meats? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you limit daily juice intake and sugar/sweets? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have concerns with your baby's bowel movements? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have concerns with your baby's sleep habits? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your baby sleeping through the night? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your baby go to a daycare home or center? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your baby always in a car seat when riding in a vehicle? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your hot water heater turned down to 120? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does your home have smoke and carbon monoxide detectors? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Is your baby exposed to secondhand smoke at home, in cars or at daycare? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you have outlet protectors and safety gates? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do you know what to do if your baby chokes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Does your baby:

- | | | |
|---|-----------------------------|------------------------------|
| Use first finger and thumb to pick up things? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Understand how to sip from a sippy cup? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Vocalize with coos and babbles? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Bang objects together? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Have any eye crossing? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Is your baby:

- | | | |
|--|-----------------------------|------------------------------|
| Quick to agitation? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Difficult to soothe? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hitting, biting, screaming or throwing tantrums? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Any questions or concerns: _____

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