9 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's…

1. Solid food intake? ☐ Yes ☐ No
2. Bowel movements, diarrhea, or constipation? ☐ Yes ☐ No
3. Congestion or wheezing? ☐ Yes ☐ No
4. Skin color or rashes (circle one)? ☐ Yes ☐ No
5. Overall development? ☐ Yes ☐ No
6. Sleep habits? ☐ Yes ☐ No

Answer the following:

7. Were there any problems with immunizations in the past? ☐ Yes ☐ No
8. Is your child exposed to tobacco smoke? ☐ Yes ☐ No
9. Have you been sad, depressed or crying excessively? ☐ Yes ☐ No
10. Does your baby co-sleep with you? ☐ Yes ☐ No
11. Does your baby use a walker? ☐ Yes ☐ No
12. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No
13. Is your water source from a well? ☐ Yes ☐ No

Does your child…

14. Say consonants like "da-da" or "ma-ma"? ☐ Yes ☐ No
15. Respond to his/her name? ☐ Yes ☐ No
16. Seem to hear well? ☐ Yes ☐ No
17. Play pat-a-cake or peek-a-boo? ☐ Yes ☐ No
18. Move all extremities equally well? ☐ Yes ☐ No
19. Explore objects by shaking, banging, or throwing them? ☐ Yes ☐ No
20. Try to pick up objects with their thumb or forefinger? ☐ Yes ☐ No
21. Sit alone for a long time? ☐ Yes ☐ No
22. Go from their tummy to sitting by their self? ☐ Yes ☐ No
23. Crawl, creep and/or scoot on their bottom? ☐ Yes ☐ No
24. Pull to a standing position? ☐ Yes ☐ No
25. Cry when a stranger approaches? ☐ Yes ☐ No

Answer the following:

26. Do you have smoke alarms? _____ Carbon monoxide detectors? _____

27. Does your child ride in a rear-facing infant car seat? ☐ Yes ☐ No
28. Do you know infant CPR? ☐ Yes ☐ No
29. Are you getting enough rest? ☐ Yes ☐ No
30. Have both parents/caregivers had the Tdap vaccine? ☐ Yes ☐ No
31. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season? ☐ Yes ☐ No
32. Is your child eating all food groups: fruits, meats, and vegetables? ☐ Yes ☐ No
33. Bottle fed infants: Is your child getting over 30 ounces per day? ☐ Yes ☐ No

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Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

1. Are you giving vitamin D? ..... ☐ Yes ☐ No
2. Breast feeding mothers, are you taking a multivitamin with iron? ..... ☐ Yes ☐ No
3. Are you having any problems nursing? ..... ☐ Yes ☐ No
4. Do you need help from our lactation specialists? ..... ☐ Yes ☐ No
5. Do you need help with preparations to return to work? ..... ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? ..... ☐ Yes ☐ No
3. Was your child or any family member born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ..... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ..... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk? ..... ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your infant is less than 12 months old with chronic lung or congenital heart disease ..... ☐ Yes ☐ No
2. Your infant was a preemie of 28 weeks or less and is less than 12 months old ..... ☐ Yes ☐ No
3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months ..... ☐ Yes ☐ No
4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder ..... ☐ Yes ☐ No
5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise ..... ☐ Yes ☐ No
6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant ..... ☐ Yes ☐ No

Lead Screening:

Does your child…

1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) ..... ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months? ..... ☐ Yes ☐ No
3. Have a sibling or playmate who now has or did have lead poisoning? ..... ☐ Yes ☐ No
4. Is your child a refugee from another country? ..... ☐ Yes ☐ No

Name and Ages of Brothers_____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ..... ☐ Yes ☐ No

_____

_____

_____

_____