9 month Visit

NAME Date

Are you concerned about your baby's…….

1. Feedings ? Finger Foods?	YES	NO
2. Bowel movements or urination ?	YES	NO
3. Congestion, wheezing or breathing?	YES	NO
4. Skin or rashes?	YES	NO
5. Excessive crying?	YES	NO
6. Overall development?	YES	NO
7. Sleep habits?	YES	NO

Does your baby…..

1. Feed self finger foods?	YES	NO
2. Respond to his/her name?	YES	NO
3. Make sounds like "mama" or "dada"?	YES	NO
4. Repeat sounds or gestures?	YES	NO
5. Seem to hear well?	YES	NO
6. Play pat-a-cake or peek-a-boo?	YES	NO
7. Try to pick up objects with thumb and forefinger?	YES	NO
8. Sit alone?	YES	NO
9. Crawl, creep or scoot on bottom?	YES	NO
10. Pull to a standing position?	YES	NO
11. Ride in a rear facing car seat in the back seat of the car?	YES	NO

Is your baby….

1. Exposed to cigarette smoke?	YES	NO
2. Attending day-care?	YES	NO
3. Chewing or mouthing peeling paint?	YES	NO
4. Able to get to exposed electrical cords or sockets?	YES	NO
5. Able to access poisons or household cleaners?	YES	NO
6. Exposed to guns or firearms?	YES	NO

LEAD SCEEN

Does your child….

1. Live or regularly visit a house built before 1950?	YES	NO
2. Live or visit a house built before 1978 with recent renovations or remodeling (with in 6 months)?	YES	NO
3. Have a sibling or playmate who now has or did have lead poisoning?	YES	NO

Dou you have any other concerns you wish to discuss? YES

Office Use ONLY

WT HT HC