



PATIENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE TODAY \_\_\_\_\_

PARENTS \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

## PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION	PHYSICIAN'S COMMENTS
<p><b>HISTORY</b></p> <p>Describe had any recent injuries or illnesses: _____</p> <p>List medications taken routinely: <input type="checkbox"/> none</p> <p>Note any new stresses in the family: _____</p> <p>Is your baby in day care? <input type="checkbox"/> No  <input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other:            How many kids? _____</p> <p>Are there any smokers in your baby's home or daycare?  <input checked="" type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room</p> <p>Does your child drink water that is fluoridated?  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p><b>NUTRITION</b></p> <p><b>Y N</b></p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is baby drinking from a cup?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Is baby finger feeding from the table?</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Has baby tolerated all foods introduced?</p> <p>How many servings per day of Meat _____            Fruit _____ Veggies _____</p> <p>How many ounces of juice per day? _____</p> <p><b>FORMULA FEEDING:</b>            How many ounces in 24 hrs? _____ What formula? _____</p> <p><b>BREAST FEEDING:</b>            How many times does baby nurse in 24 hours?            How many minutes is each feeding?</p> <p><b>Y N</b></p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Have you given supplemental formula?</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Are you pumping breast milk?</p> <p><b>Y N</b></p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Does baby spit up? If yes, how many times per day?</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Are there any problems passing stool?</p>	<p><input type="checkbox"/> Discussed risks of 2<sup>nd</sup> hand smoke.</p> <p><input type="checkbox"/> Prescribed fluoride vitamins.</p> <p><b>Shaded items are new for the 9 mo check-up.</b></p> <p><b>GENERAL FEEDING RECOMMENDATIONS</b></p> <p><input type="checkbox"/> Formula with iron until age 1.</p> <p><input type="checkbox"/> Iron fortified rice cereal, 2 tsp/day.</p> <p><input type="checkbox"/> #3 baby food jars and/or finger foods from table.</p> <p><input type="checkbox"/> Use cup more and bottle less (if on bottle).</p> <p><input type="checkbox"/> Don't let bottle be a toy (harder to wean).</p> <p><input type="checkbox"/> Never allow a bottle in bed (causes cavities).</p> <p><input type="checkbox"/> Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins.</p> <p><input type="checkbox"/> Fluoride and Vitamins only if prescribed.</p> <p><b>BREAST FEEDING RECOMMENDATIONS</b></p> <p><input type="checkbox"/> Should be sleeping through the night.</p> <p><input type="checkbox"/> May follow lower % on weight growth curve.</p> <p><input type="checkbox"/> Nurse until at least 1 year old, if possible.</p> <p><input type="checkbox"/> 6-12 feedings in 24 hrs is typical.</p> <p><input type="checkbox"/> Baby is easily distracted, not disinterested.</p> <p><input type="checkbox"/> Nurse in a quiet place.</p> <p><input type="checkbox"/> Nursing for comfort is common.</p> <p><input type="checkbox"/> Back to work? Pump and freeze milk properly.</p> <p><input type="checkbox"/> Mom should not diet. Drink to thirst.</p> <p><b>STOOLING EXPECTATIONS</b></p> <p><input type="checkbox"/> Stool frequency is variable, but should not be hard balls.</p> <p><input type="checkbox"/> Ambulation and safety</p> <p><input type="checkbox"/> Catch'em being good</p>

PHYSICAL EXAM	LAB	IMMUNIZATIONS																				
<p>Ht _____ Wt _____ HC _____ VS: _____</p> <p>Check if normal:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Back</td> </tr> <tr> <td><input type="checkbox"/> Eyes/Red reflexes</td> <td><input type="checkbox"/> Mouth</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Ears</td> <td><input type="checkbox"/> Throat</td> <td><input type="checkbox"/> Femoral pulses</td> <td><input type="checkbox"/> Extremities</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Genitalia</td> <td><input type="checkbox"/> Neurologic</td> </tr> </table> <p>NOTE EXAM ABNORMALITIES HERE</p>	<input type="checkbox"/> Head	<input type="checkbox"/> Nose	<input type="checkbox"/> Lungs	<input type="checkbox"/> Back	<input type="checkbox"/> Eyes/Red reflexes	<input type="checkbox"/> Mouth	<input type="checkbox"/> Heart	<input type="checkbox"/> Hips	<input type="checkbox"/> Ears	<input type="checkbox"/> Throat	<input type="checkbox"/> Femoral pulses	<input type="checkbox"/> Extremities		<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin		<input type="checkbox"/> Chest	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Neurologic	<p><input type="checkbox"/> Hgb</p> <p><input type="checkbox"/> Lead</p> <p><input type="checkbox"/> PPD placed</p> <p>Other: _____</p>	<p><input type="checkbox"/> Given at Health Department</p> <p>Shots up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any previous side effects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what? _____</p> <p><input type="checkbox"/> DTaP <input type="checkbox"/> HepB</p> <p><input type="checkbox"/> IPV <input type="checkbox"/> Hib</p> <p><input type="checkbox"/> Comvax <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Pevnar</p>
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### ASSESSMENT

- NORMAL GROWTH and DEVELOPMENT. More information on other side.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### PLAN

- Follow up at **12 months** for Health Review.  Anticipatory handouts given.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

DEVELOPMENTAL ASSESSMENT	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's development?	
<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Does baby turn his/her head toward sounds? <input type="checkbox"/> <input type="checkbox"/> Does baby see OK?	
<b>M O T O R</b>	<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Does s/he scoot, crawl, creep on hands and knees? <input type="checkbox"/> <input type="checkbox"/> Does s/he sit alone? <input type="checkbox"/> <input type="checkbox"/> Does s/he pull to a stand and cruise around furniture? <input type="checkbox"/> <input type="checkbox"/> Does baby pick up small items with the thumb and finger?
	<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Do you talk, read, sing and play games with baby? <input type="checkbox"/> <input type="checkbox"/> Does s/he imitate sounds such as "mama" and "dada"? <input type="checkbox"/> <input type="checkbox"/> Does s/he use hard consonant sounds? (B,D,G,K, etc) <input type="checkbox"/> <input type="checkbox"/> Does baby respond to his/her own name? <input type="checkbox"/> <input type="checkbox"/> Does s/he wave "bye-bye"? <input type="checkbox"/> <input type="checkbox"/> Does s/he react to "no-no"?
	<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Does baby look for a toy that they watched you hide? <input type="checkbox"/> <input type="checkbox"/> Does baby enjoy peek-a-boo, so-big and pat-a-cake? <input type="checkbox"/> <input type="checkbox"/> Does s/he react to strangers with anxiety or shyness? <input type="checkbox"/> <input type="checkbox"/> Does s/he seem to be "teething"? (Some don't get teeth until after 1 year old.)
	<b>L A N G U A G E</b>

BEHAVIOR RECOMMENDATIONS	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's behavior?	
<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Is your baby becoming more independent? (normal) <input type="checkbox"/> <input type="checkbox"/> Do you show affection regularly? <input type="checkbox"/> <input type="checkbox"/> Do you praise good behavior frequently? (time-in) <input type="checkbox"/> <input type="checkbox"/> Do you remove attention when doing unacceptable behavior? <input type="checkbox"/> <input type="checkbox"/> Do you set limits and choose your battles wisely? <input type="checkbox"/> <input type="checkbox"/> Do you occasionally say "no"? <input type="checkbox"/> <input type="checkbox"/> Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers? <input type="checkbox"/> <input type="checkbox"/> Do you try to ignore tantrums? (very typical)	
<b>S L E E P</b>	<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Are you satisfied with baby's sleep habits? (Separation anxiety may cause sleep problems.) <input type="checkbox"/> <input type="checkbox"/> Does s/he have a security toy/blanket for awakenings? <input type="checkbox"/> <input type="checkbox"/> Do you maintain a bedtime routine? <input type="checkbox"/> <input type="checkbox"/> Does your baby nap twice daily? (typical) <input type="checkbox"/> <input type="checkbox"/> Are you OK with your baby's use of self-comforting behaviors? <input type="checkbox"/> thumb sucking <input type="checkbox"/> pacifier <input type="checkbox"/> <input type="checkbox"/> favorite object <input type="checkbox"/> none <input type="checkbox"/> <input type="checkbox"/> Do you avoid giving baby a bottle in the crib? (cavities)
	Where does baby usually sleep?

SAFETY AWARENESS	
Please review the shaded items, which are new for the 9 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/> You may skip to the "TB Risk" box.	
<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Do you watch closely around lakes, wells, buckets and toilets? <input type="checkbox"/> <input type="checkbox"/> Is the car seat rear facing in the back seat? → <input type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy? <input type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of reach? <input type="checkbox"/> <input type="checkbox"/> Do you always monitor your child while s/he is in the bath tub? <input type="checkbox"/> <input type="checkbox"/> Do you have gates to guard open stairways? <input type="checkbox"/> <input type="checkbox"/> Are sharp table edges protected? <input type="checkbox"/> <input type="checkbox"/> Do you avoid the use of baby walkers?	If baby is outgrowing the infant carrier car seat (usually at around 20 lbs) switch to a "convertible" car seat. It must remain rear facing until both 1 yr old AND 20 lbs.
<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on? <input type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage that may be hazardous? <input type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your child? <input type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach? <input type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure? <input type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers? <input type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair?	

TUBERCULOSIS (TB) RISK	
<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Has your child been around anyone with contagious TB or a positive PPD test? <input type="checkbox"/> <input type="checkbox"/> Has your child had contact with people from Asia, Middle East, Africa or Latin America? <input type="checkbox"/> <input type="checkbox"/> Is anyone living in your house infected with HIV? <input type="checkbox"/> <input type="checkbox"/> Has your child been exposed to any of the following people: homeless, nursing home residents, institutionalized people, jail / prison inmates, users of illicit drugs, migrant farm workers. <input type="checkbox"/> <input type="checkbox"/> Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?	TB Risk: <input type="checkbox"/> High <input type="checkbox"/> Low

LEAD RISK	
<b>Y N</b> <input type="checkbox"/> <input type="checkbox"/> Does your child live in or visit a house built before 1978? <input type="checkbox"/> <input type="checkbox"/> Is there a sibling or playmate with lead poisoning? <input type="checkbox"/> <input type="checkbox"/> Does s/he live with someone involved in the following: furniture refinishing or making stained glass or pottery, storage of batteries, using indoor gun firing ranges, automotive repair, construction of bridges, tunnels or elevated highways? <input type="checkbox"/> <input type="checkbox"/> Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead? <input type="checkbox"/> <input type="checkbox"/> Does s/he have unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?	Lead Risk: <input type="checkbox"/> High <input type="checkbox"/> Low

Who answered the above questions? \_\_\_\_\_ Thank you for helping us help you and your child!!  
**Please put this paper in the box hanging outside the door so that we know you are finished!**