9 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have any concerns about your baby's health?	NO	YES
2	Has your baby had any problems with shots or immunizations?	NO	YES
3	Does your baby receive health care from anyone besides a medical doctor, nurse practitioner or physician's assistant (acupuncturist, chiropractor, naturopath)?	NO	YES

Review of Systems

4	Do you have any concerns about your baby's hearing?	NO	YES
5	Do you have any concerns about your baby's vision?	NO	YES
6	Does your baby ever appear cross-eyed?	NO	YES

Feeding/Nutrition

7	Is your child breastfeeding well?	YES	NO	DOESN'T APPLY
	a. How many times a day does your baby breastfeed?			
8	Is your baby taking (drinking) formula?	YES	NO	
	a. How many ounces of formula is your baby drinking a day?			
	b. Which formula are you feeding your baby?			
9	Is your baby getting 3 meals of solid foods per day?	YES	NO	
10	Is your baby trying to feed him or herself?	YES	NO	
11	Does your baby drink juice or other sweetened drinks?	NO	YES	
12	Is your baby taking an infant multivitamin D supplement? (If your baby is taking more than 34 ounces of formula per day, you do not need to be giving a supplement).	YES	NO	
13	Have you introduced common allergen foods like eggs, peanuts, tree nuts, soy, dairy, fish or shellfish into your baby's diet? (Please note these should be given in a form that your baby will not choke on such as peanut butter or pureed shellfish)	YES	NO	

Oral Health

14 Does your baby fall asleep with a bottle and/or wake at night to breast or bottle feed?	NO	YES
15 Are you using a soft toothbrush or cloth with fluoridated toothpaste (size of a grain of rice) to clean your baby's teeth and gums 2 times per day?	YES	NO
16 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
17 Has any caregiver had cavities/dental decay in the past year?	NO	YES

Elimination

18 Does your baby have any problems with bowel movements (going poop)?	NO	YES
19 Do you have any concerns about your baby's urination (peeing)?	NO	YES

Activity / Exercise / Screen Time

20 Does your baby have screen time (smartphone, tablet, TV)?	NO	YES
21 Do you read to your baby every day?	YES	NO
22 Does your baby get supervised floor time every day?	YES	NO

Sleep

23 Does your baby fall asleep on his/her own?	YES	NO
24 Do you have a bedtime routine?	YES	NO

Social Stressors

25 Have there been any major changes or stresses in your family recently?	NO	YES	
26 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
27 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
28 Do you always feel safe in your home?	YES	NO	

Lead

29 Is your baby regularly in a house built before 1978?	NO	YES
a. Is there any peeling or chipping paint or are you remodeling?	NO	YES
30 Does your baby have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

31 Do you always stay close enough to touch your baby when he or she is in the bath?	YES	NO	
32 Do you keep furniture away from windows or use window guards?	YES	NO	
33 Does your baby wear any jewelry (including necklaces)?	NO	YES	
34 Do you hold or carry hot liquids around the baby?	NO	YES	
35 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO	
36 Does anyone smoke or vape around your baby?	NO	YES	
37 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
38 If your child has fair skin, do you apply sunscreen if out in the sun for longer than 15-30 minutes?	YES	NO	DOESN'T APPLY
39 Do you keep plastic bags and latex balloons away from your baby?	YES	NO	
40 Is your water heater turned to below 120 degrees?	YES	NO	
41 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO	
42 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
43 Do you have the number for Poison Control?	YES	NO	
44 Does your baby use a seated infant walker?	NO	YES	

Tuberculosis

45 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
46 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
47 Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
48 Has your baby traveled to a high-risk country for more than a month?	NO	YES