Health Maintenance Questionnaire

9 MONTHS

LINCOLN PEDIATRIC GROUP

Today's Date:

PATIENT NAME: Birth Date:

PARENTS: Age Today:

PARENTS' CONCERNS

List concerns you have? 1.
2.
3.
4.
5.

Please check 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

HISTORY

Describe any recent injuries or illnesses:

List medications taken routinely: ☐none

Note any new stresses in the family:

Is your baby in day care? ☐No ☐Home based ☐Center based ☐Nanny
How many kids? Other:

Are there smokers in your baby's home or day care? ☐No ☐outside ☐other room

Where does your child get fluoride for their dental health?
Formula mixed with fluoridated: ☐city water ☐bottled water ☐natural / well water

☐city water ☐fluoride rinse / recs from dentist
☐natural fluoride in water ☐fluoride vitamin ☐no known fluoride ☐not sure

NUTRITION

Y N
☐☐Is baby drinking from a cup?
☐☐Is baby finger feeding from the table?
☐☐Has baby tolerated all foods introduced?
How many servings per day of Meat Fruit Veggies
How many ounces of juice per day?

FORMULA FEEDING:
How may ounces in 24 hrs? What formula?

BREAST FEEDING:
How many times does baby nurse in 24 hours?
How many minutes is each feeding?

Y N
☐☐Have you given supplemental formula?
☐☐Are you pumping breast milk?

Y N
☐☐Does baby spit up? If yes, how many times per day?
☐☐Are there any problems passing stool?

- Avoid 2nd hand smoke.

GENERAL FEEDING RECOMMENDATIONS

- Formula with iron until age 1.
- Iron fortified rice cereal, 2 tbsp/day.
- #3 baby food jars and/or finger foods from table.
- Use cup more and bottle less (if on bottle).
- Don't let bottle be a toy (harder to wean).
- Never allow a bottle in bed (causes cavities).
- Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins.
- Fluoride and Vitamins only if prescribed.

BREAST FEEDING RECOMMENDATIONS

- 6-12 feedings in 24hrs is typical
- Probably sleeping through the night.
- Don't go more than 5hrs at night without removing milk (pump if baby sleeps longer)
- If baby is supplemented with pumped breast milk or formula → pump (supply : demand)
- May follow lower % on the weight growth curve
- Nurse until at least 1 year old if possible
- Needs at least 24oz of milk per day, so don't replace milk intake with food.
- Baby is easily distracted, not disinterested. Nurse in a quiet place.
- Nursing for comfort is common.
- Back to work? Pump/freeze milk properly.
- Never allow a bottle in bed or continuous suckling during the night, as this may contribute to cavities.
- Mom should not diet. Drink to thirst.
- Vitamin D 1ml per day if fed mostly breast milk.

STOOLING EXPECTATIONS

Stool frequency is variable, but should not be hard balls.

PHYSICAL EXAM

Ht____ Wt____ HC___ VS:_____

Head	Nose	Lungs	Back
Eyes/Red reflexes	Mouth	Heart	Hips
Ears	Throat	Femoral pulses	Extremities
	Neck	Abdomen	Skin
	Chest	Genitalia	Neurologic

LAB

Hgb
Lead
PPD placed
Other:

IMMUNIZATIONS

☐Given at Health Department
Shots up to date? ☐Yes ☐No
Any previous side effects? ☐Yes ☐No
If yes, what?

ASSESSMENT

PLAN

PLEASE COMPLETE OTHER SIDE OF FORM

Patient Name: Birth Date:

9 month

DEVELOPMENTAL ASSESSMENT

☐Yes ☐No Are you concerned about your child's development?

Y N
☐☐Does baby turn his/her head toward sounds?
☐☐Does baby see OK?

MOTOR

Y N
☐☐Does s/he scoot, crawl, creep on hands and knees?
☐☐Does s/he sit alone?
☐☐Does s/he pull to a stand and cruise around furniture?
☐☐Does baby pick up small items with the thumb and finger?

LANGUAGE

Y N
☐☐Do you talk, read, sing and play games with baby?
☐☐Does s/he imitate sounds such as "mama" and "dada?"
☐☐Does s/he use hard consonant sounds? (B,D,G,K, etc)
☐☐Does baby respond to his/her own name?
☐☐Does s/he wave "bye-bye?"
☐☐Does s/he react to "no-no?"

SOCIAL

Y N
☐☐Does baby look for a toy that they watched you hide?
☐☐Does baby enjoy peek-a-boo, so-big and pat-a-cake?
☐☐Does s/he react to strangers with anxiety or shyness?
☐☐Does s/he seem to be "teething?"
(Some don't get teeth until after 1 year old.)

BEHAVIOR RECOMMENDATIONS

☐Yes ☐No Are you concerned about your child's behavior?

Y N
☐☐Is your baby becoming more independent? (normal)
☐☐Do you show affection regularly?
☐☐Do you praise good behavior frequently? (time-in)
☐☐Do you remove attention when doing unacceptable behavior?
☐☐Do you set limits and choose your battles wisely?
☐☐Do you occasionally say "no?"
☐☐Do you use distractions to redirect attention from unacceptable behaviors and remove your child from dangers?
☐☐Do you try to ignore tantrums? (very typical)

SLEEP

Y N
☐☐Are you satisfied with baby's sleep habits?
(Separation anxiety may cause sleep problems.)
☐☐Does s/he have a security toy/blanket for awakenings?
☐☐Do you maintain a bedtime routine?
☐☐Does your baby nap twice daily? (typical)
☐☐Are you OK with your baby's use of self-comforting behaviors?
☐thumb sucking ☐pacifier
☐favorite object ☐none
☐☐Do you avoid giving baby a bottle in the crib? (cavities)
Where does baby usually sleep?

SAFETY AWARENESS

The shaded items are new for the 9 month visit.

Y N
☐☐Do you watch closely around lakes, wells, buckets and toilets?
☐☐Is the car seat rear facing in the back seat? ----------→
☐☐Do you have the Poison Control center's number handy?
☐☐Are medications, poisons and plants out of reach?
☐☐Do you always monitor your child while s/he is in the bath tub?
☐☐Do you have gates to guard open stairways?
☐☐Are sharp table edges protected?
☐☐Do you avoid the use of baby walkers?

Car seat is rear facing until 2 yrs old or until they reach the highest weight or height allowed by car seat's manufacturer.

Y N
☐☐Do you keep small items out of reach which baby could choke on?
☐☐Do you check toys for breakage that may be hazardous?
☐☐Do you keep balloons and plastic wrappers away from your child?
☐☐Is the water temperature in your house less than 120 degrees?
☐☐Do you have a fire escape plan?
☐☐Do you check your smoke detectors regularly?
☐☐Do you keep your curling iron out of reach?
☐☐Do you limit sun exposure?
☐☐Have you inserted electrical outlet covers?
☐☐Do you watch for frayed electrical cords in need of repair?

TUBERCULOSIS (TB) RISK

TB Risk:
☐High ☐Low

Y N
☐☐Has your child been around anyone with contagious TB or a positive PPD test?
☐☐Has your child had contact with people from Asia, Middle East, Africa or Latin America?
☐☐Is anyone living in your house infected with HIV?
☐☐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.
☐☐Does your child have cancer, diabetes, kidney failure, HIV, poor nutrition or an immunosuppressive condition?

LEAD RISK

Lead Risk:
☐High ☐Low

Y N
☐☐Does your child live in or visit a house built before 1978?
☐☐Is there a sibling or playmate with lead poisoning?
☐☐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?
☐☐Does your child live near: an active smelter, battery recycling plant, mine tailing pile, other industry likely to release lead?
☐☐Does s/he have unexplained developmental delay, hearing problem, irritability, severe attention deficit, violent tantrums or unexplained anemia?

Who answered the above questions? *Thank you for helping us help you and your child!!*