Health Maintenance Questionnaire

9 MONTHS

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:

Will Mom return to work/school? ☐No ☐at ____ wks old ☐is back to work/school

Will baby go to day care? ☐No ☐Yes ☐Nanny ☐In day care now.
How many kids in the room/home? _____

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

- Avoid 2nd hand smoke.

Y N
☐☐Does baby seem to be "teething?"
Dental visits are recommended within 6 months of the first tooth erupting, so 12months old is typical. Clean teeth regularly. Never allow a bottle in bed or continuous suckling during the night, as this contributes to cavities.

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:

In the past 24 hours:

Latched _____ times

Pumped _____ times Total ounces: _____

Fed _____ ounces of pumped milk Fed _____ ounces of formula– type:_____

GENERAL FEEDING RECOMMENDATIONS
- Formula with iron until age 1.
- #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).
- Avoid nuts, popcorn, hot dogs, raw carrots, frozen peas, celery, apples, grapes, raisins.
- Vitamins only as prescribed by the doctor.

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.
- Mom should not diet. Drink to thirst.
- Vitamins as prescribed by the doctor.

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

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

PHYSICAL EXAM	Lab/Immunizations
Ht_______ Wt________ HC_______ VS:________________________ EXAM:	

ASSESSMENT	PLAN

PLEASE COMPLETE OTHER SIDE OF FORM 11/18

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?

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

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?

2019 Nebraska Car Seat Law: Kids ride rear-facing until they turn 2. It is safest to stay rear-facing for as long as possible, until they reach the upper weight or height limit allowed by the car seat's manufacturer. Kids under 8 must ride in the back seat.

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!!*