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 child receive health care from anyone besides a medical doctor (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
	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 2-3 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 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

Elimination

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

Activity / Exercise / Screen Time

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

Sleep

22 Does your baby sleep at least 6 to 8 hours without waking up at night?	YES	NO
23 Does your baby fall asleep on his/her own?	YES	NO
24 Do you have a bedtime routine?	YES	NO

Social Stressors

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

Lead

30 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
31 Does your baby have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

32 Do you always stay close enough to touch baby when he or she is in the bath?	YES	NO	
33 Do you keep furniture away from windows or use window guards?	YES	NO	
34 Does your baby wear any jewelry (including necklaces)?	NO	YES	
35 Do you hold or carry hot liquids around the baby?	NO	YES	
36 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO	
37 Does anyone smoke or vape around your baby?	NO	YES	
38 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO	
39 Are you using a shade or sunscreen if your baby is in the sun more than 15-30 minutes?	YES	NO	
40 Do you keep plastic bags and latex balloons away from your baby?	YES	NO	
41 Is your water heater turned to below 120 degrees?	YES	NO	
42 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO	
43 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO	
44 Do you have the number for Poison Control?	YES	NO	
45 Does your baby use a seated infant walker?	NO	YES	
46 If there is a gun in the home, is it locked in a safe with the ammunition stored separately?	N/A	YES	NO

Tuberculosis

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