Well Child Health Screen: 9 Months

Name: ______________________________ **Birthdate**: ______________ **Visit Date:**________________

General Health Updates

Who is completing this form?	☐ Mom ☐ Dad ☐ Other, please list:
Any questions, concerns, or problems you want to discuss today?	
Any updates to the patient's health? (i.e. new conditions, surgeries, etc.)	
Any family health, family status or social updates we should be aware of?	
Any concerns about development, learning or behavior?	
Who lives with the patient?	
Any smoke or e-cigarette exposure?	
Anything else you want to share? (milestones, proud moments, etc.)	

Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

Do you have concerns about their eyes or vision?	☐ Yes ☐ No
Do you have concerns about their hearing?	☐ Yes ☐ No

Family Life

Are there barriers that prevent you from spending time each day interacting with them?	☐ Yes ☐ No
Does anyone in the home/family have problems with drugs or alcohol?	☐ Yes ☐ No ☐ Decline

Nutrition

Do you have concerns or questions about what or how they are eating?	☐ Yes ☐ No
Do they drink juice?	☐ Yes ☐ No

Oral Health

Does anyone in the house have current dental decay/cavities?	☐ Yes ☐ No ☐ Unknown

Do they take extra fluoride OR drink water that contains fluoride?	☐ Yes ☐ No ☐ Unknown
Do you brush their teeth or gums twice a day?	☐ Yes ☐ No
Fluoride varnish is recommended in some children up to 4 times a year. If they have teeth, are you interested in having fluoride applied during this visit?	☐ Yes ☐ No ☐ Maybe

Sleep

Healthy sleep is important for growth, development, and learning. Infants and toddlers may sleep 15-18 hours in a day, while school-aged children should be getting more than 10 hours a day. We do not recommend having a screen in their bedroom as this can affect sleep.

Where do they sleep?	☐ Crib ☐ Bed ☐ Co-sleep ☐ Other:
Do you put them to sleep on their back?	☐ Yes ☐ No
Do you have any concerns about the amount or quality of their sleep?	☐ Yes ☐ No

Activity & Screen Time

Does the patient spend any time in front of a screen (TV, phone, video games, etc.)?	☐ Yes ☐ No

Safety

Have you completed the items on the Home Safety Checklist?	☐ Yes ☐ No
Is the baby riding in a rear-facing car safety seat in the backseat every time in a vehicle?	☐ Yes ☐ No
Do you have questions about how to keep them safe around water?	☐ Yes ☐ No
Do you have any questions about how to demonstrate safe behavior around pets and animals?	☐ Yes ☐ No