PEDIATRIC HEALTH MAINTENANCE – 9 Months

Parent Questionnaire

General

Do you have any concerns or questions you would like to discuss today?	☐ No	☐ Yes
If yes, please specify:		
Is your child in daycare or the care of another person outside parents?	☐ No	☐ Yes
Do you have any concerns about your child's vision or hearing?	☐ No	☐ Yes
Do your child's eyes ever appear to cross or drift apart?	☐ No	☐ Yes

Feeding and Sleeping

What is your baby fed?	☐ Breast milk	☐ Formula	☐ Milk	☐ Other
Ounces per feeding (if bottle fed):				
Number of breast or bottle feedings in 24 hours:		Number of feedings overnight:		
Are you giving your child any vitamins?	☐ No	☐ Vitamin D	☐ Iron	☐ Other
Solid foods (list examples)				
Is there fluoride in your water?	☐ Yes	☐ No	☐ Don't know	
Do you think your baby's bowel movements are normal?			☐ Yes	☐ No
Does your child sleep through the night?			☐ Yes	☐ No

Development

Does your child look when you call their name?	☐ Yes	☐ No
Does your child smile or laugh when you play peek-a-boo?	☐ Yes	☐ No
Does your child look for objects when dropped out of sight (like his spoon or toy)?	☐ Yes	☐ No
Does your child bangs two things together?	☐ Yes	☐ No
Can your child get to a sitting position by themself?	☐ Yes	☐ No
Can your child move things from one hand to their other hand?	☐ Yes	☐ No
Does your child use their fingers to "rake" food towards himself?	☐ Yes	☐ No
Can your child sit without support?	☐ Yes	☐ No
Please share any concerns about your child's development		

Safety

Are small objects kept out of baby's reach at all times (e.g. coins, siblings' small toys, peanuts)?	☐ Yes	☐ No
Have you started to babyproof your home?	☐ Yes	☐ No
Does your child ride in a rear-facing car seat, in the back seat?	☐ Yes	☐ No
Are there smokers in your home?	☐ No	☐ Yes
Do you have a firearm in your home?	☐ No	☐ Yes
If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them?	☐ Yes	☐ No
Are you afraid of your partner or anyone close to you?	☐ No	☐ Yes
Do you feel overly stressed or unsupported?	☐ No	☐ Yes

Completed by (name and relationship to patient)

Date (month/day/year)

PATIENT NAME

VIRGINIA MASON FRANCISCAN HEALTH
Pediatric Health Maintenance – 9 Months

VMMC99169 (03-25)