Woodinville Pediatrics 9 Month Questionnaire

Patient Name:_____ Date:_____

Parental concerns this visit: _____
_____

Current Medications: _____
Current Allergies: _____

Family
Concerns about maternal depression ____yes ____no
Parents working outside home ____mother ____father
Child Care ____yes ____no Type_____
Changes since last visit _____

Diet
Milk _____
Type _____
Milk Amount/Time_____
Solid Food Comments _____
Source of water _____ Vitamins/Fluoride_____

Bowel/Bladder
Stool Concerns ____yes ____no
Stool Consistency ____hard ____soft
Urination Concerns ____yes ____no

Sleep
Back sleeping ____yes ____no
Location ____co-sleep ____crib ____co-sleep & crib
Duration ____ < 3 hrs ____ 3-6 hrs ____ > 6 hrs

Tobacco Exposure ____yes ____no

Behavior Concerns ____yes ____no

Activity (play time, no TV) _____

Development
Social Emotional: ___ Stranger Anxiety ___Seeks parent for comfort
Communication: ___ Imitates sounds
___ Points out objects
Cognitive: ___Peekaboo ___Object permanence ___Looks at books
Physical : ___Sits well ____crawls ___Pulls to feet with support

Additional comments: _____

_____