



PATIENT NAME: _____

Questions for 9 Month Visit

DATE: ____ / ____ / ____

Please complete the following questions as they apply to your infant.

NUTRITION

Breastfeeding

Are you breast feeding? yes no

Regarding breast feeding, are you?

exclusively breast feeding exclusively pumping breast feeding and pumping breast feeding and supplementing with formula

Approximately how long does your infant feed from each breast?

< 10 minute > 10 minutes

Approximately how many feedings does your infant take in a 24 hour period?

<4 4 to 6 > 6

Are you planning on weaning at this time? yes no

Formula

Regarding formula, is your infant?

completely formula fed supplemented with formula after breast feeding not formula fed

How many ounces does your infant take per feeding?

< 4 oz 4 to 6 oz 6 to 8 oz > 8 oz

Approximately how many feedings does your infant take in a 24 hour period?

<5 5 to 6 >6

What type of formula do you feed your infant?

Enfamil Lipil Similac Advance Nestle Goodstart Isomil Prosobee Nutramigen
 Enfacare Neosure Other: _____

Additional Liquids

Has your infant started to drink from a cup? yes no

Has your infant started to drink juice? yes no

If yes, how much per day?

0 to 4 oz 4 to 8 oz > 8 oz

Your infant has (or will have) what type of water source?

city well bottled with fluoride bottled without fluoride

Solids

Has your infant started solid (complementary) foods? yes no

If yes, what type?

iron fortified cereal stage 1 products stage 2 products stage 3 products home-made baby foods
 table foods

ELIMINATION

How many wet diapers does your infant have per day?

> 6 < 6

How frequent does your infant have a bowel movement?

> 6 per day 3 to 6 per day 1 to 2 per day 1 per day

every other day every 3 to 4 days > every 4 days

Is your infant having any problems with his/her bowel movements? yes no

If yes, please explain: _____

SLEEP

How many hours does your infant sleep at night?

< 8 8 to 10 10 to 12 > 12

How many naps does your infant take during the day?

none 1 2 3 >3

Is your infant using a pacifier to fall asleep? yes no

Are you establishing a bedtime ritual? yes no

Are you placing your infant to sleep partially or fully awake? yes no

Is your infant waking at night to feed? yes no

Is your infant waking at night other than to feed? yes no

Is your infant sleeping with a bottle? yes no

Where is your infant sleeping?

in a bed with his/her caregiver(s) in a bassinet in his/her caregiver(s) room in a crib in his/her caregiver(s) room
 in a crib in a separate room from his/her caregiver(s) Other: _____

VISION

Do you have any concerns regarding your infant's vision? yes no

If yes, please explain: _____

HEARING

Do you have any concerns regarding your infant's hearing? yes no

If yes, please explain: _____

DEVELOPMENT

Turns his/her head to localize to sound (even those that originate from behind the infant) yes no

Responds to own name yes no

Sits independently without support yes no

Crawls or creeps on hands and knees yes no

Pulls to stand yes no

Holds own bottle yes no

Uses pincer grasp yes no

Feeds self with fingers yes no

Deliberately drops or throws things yes no

Bangs, strikes and shakes toys yes no

Is becoming wary of unfamiliar people yes no

Understands a few words such as "no-no" and "bye-bye" yes no

SAFETY

What type of car seat does your infant use?

a 5 point (rear facing) infant carrier in the back seat of the vehicle
 a 5 point (rear facing) toddler (convertible) seat in the back seat of the vehicle
 Other: _____

Do you have a pool? yes no

If yes, what type?

above ground without a fence in ground without a fence above ground with a fence around the pool above ground with a fence around the yard
 in ground with a fence around the pool in ground with a fence around the yard

J.A.N. 27.2010 Signature of Provider _____ Date: ____ / ____ / ____



PATIENT NAME: _____

PROVIDER: _____ DATE: ____/____/____ ZIP CODE: _____

Lead Screening

A documented result of a blood lead test or a properly filled out Childhood Lead Risk Assessment Questionnaire must be attached to a Certificate of Child Health Examination form for purposes of admission to an Illinois Department of Children and Family Services or state regulated child-care facility, including those operated by a school district.

Respond to the following questions by checking the appropriate answer.

- | | | | |
|--|------------------------------|-----------------------------|----------------------------------|
| Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does this child have a sibling with a blood lead level of 10 mcg/dL or higher? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does this child live in or regularly visit a home that was built before 1978? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Is this child a refugee or an adoptee from any foreign country? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

M.A.R. 5.2010 Signature of Provider _____ Date: ____/____/____