Reedsburg AREA MEDICAL CENTER
Physicians Group

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Patient Questionnaire – Nine-Month Well Child

Patient Name:_____ Date of Birth:___/___/___ Date:_____

History Provided By (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Lives With (please circle)	Mother Stepparent Grandmother Aunt Father Brother Grandfather Foster Parent Legal Guardian Sister Uncle Caseworker
Interval Problems (please circle)	Caregiver depression Lack of social support Recent illness Caregiver stress Marital discord Recent injury Chronic caregiver stress at home
Nutrition	
Milk Source (please circle)	Breastfeeding Cow's Milk Formula
Additional Intake (please circle)	Solids Water Non-nutritional
Feeding Problems (please circle)	Burping Poorly Spitting Up Vomiting
Breast Feeding	
Frequency of Feedings (please circle)	Every 1-3 hours Every 6-8 hours 5-8 times per 24 hours Every 4-5 hours 1-4 times per 24 hours 9-12 times per 24 hours **Ounces per 24 hours: _____**
Pumped (please circle)	Yes No

Please see reverse side

Formula	
Type of Formula (please circle)	Cow's milk based Low Iron Premature Extensively Hydrolyzed Metabolic Soy Lactose Free **Ounces per Feeding: _____** **Ounces per 24 hours: _____**
Frequency of Feedings (please circle)	Every 1-3 hours Every 6-8 hours 5-8 times per 24 hours Every 4-5 hours 1-4 times per 24 hours 9-12 times per 24 hours
Cereal	
Cereal Type (please circle)	Barley Corn Oat Rice
Solid Foods	
Types of Intake (please circle)	Fruits Meats Vegetables
Food Consistency (please circle)	Pureed Foods Stage II Foods Stage III Foods Table Foods
Dental	
Teething Symptoms (please circle)	Yes No
Tooth Eruption (please circle)	Not evident Beginning In progress Complete
Elimination	
Urinary Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours With every feeding 1-3 times per 24 hours More than 6 times per 24 hours
Stool Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours Once per 48 hours 1-3 times per 24 hours With every feeding Once per 72 hours 4-6 times per 24 hours
Stool Consistency (please circle)	Formed Hard Loose Seedy Watery
Elimination Problems (please circle)	Colic Diarrhea Urinary Symptoms Constipation Gas

Sleep				
Sleep Location (please circle)	Bassinet	Crib	Parent's Bed	
How child falls asleep (please circle)	Bottle is in crib	In caretaker's arms while feeding	On own	
	In caretaker's arms			
Sleep Position (please circle)	Supine (on back)	On side	Prone (on stomach)	
	Average sleep duration in hours: _____			
Safety/Environment				
Home is child-proofed (please circle)	Yes	No	Partially	
Smoking in home (please circle)	Yes	No		
Working smoke alarms (please circle)	Yes	No	Don't know	
Working CO (carbon monoxide) alarms (please circle)	Yes	No	Don't know	
Car seat (please circle)	Yes	No		
Screening				
Immunizations up-to-date (please circle)	Yes	No	**Risk factors for oral health** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes	No	**Risk factors for lead toxicity** (please circle)	Yes No
Social				
Caregiver enjoys child (please circle)	Yes	No		
Childcare location (please circle)	Child's home	Daycare	Another residence	
Childcare provider (please circle)	Parent	Relative	Babysitter	Daycare provider
Days per week at daycare: _____				
Hours per day at daycare: _____				

Please see reverse side

Growth and Development

Do you or your family/childcare provider have concerns about your baby's speech, learning, motor skills or behavior? (please circle)

Yes No

Does your baby:

Interact by smiling and making sounds with his/her voice? (please circle)

Yes No

Imitate sounds? (please circle)

Yes No

Express emotions? (please circle)

Yes No

Babble (say ma-ma-ma without meaning mama)? (please circle)

Yes No

Sit up without much support? (please circle)

Yes No

Move object from one hand to the other hand? (please circle)

Yes No

Feed self a cracker? (please circle)

Yes No

Pick up small objects such as a Cheerio? (please circle)

Yes No

Stand while holding on to couch or other stable object? (please circle)

Yes No

Wave "bye-bye"? (please circle)

Yes No

Play hand games such as "pat-a-cake" or "so big"? (please circle)

Yes No