Name: _____ Date of birth: _____

Health Status Questionnaire – 9 Months

Baby lives with: mother father both parents other:_____

Childcare: daycare babysitter stays at home other:_____

Car seat use: Y N
Sunscreen/protection: Y N
Insect protection: Y N
Home child proofed: Y N

Smoke detectors: Y N
Fire extinguishers: Y N
Firearms/guns in house: Y N
Locked away: Y N
Passive smoke exposure: Y N

Breastfeeding? Y N Every ____ hours For _____ minutes per side
Formula feeding? Y N Formula:_____
____ oz every ____ hours, _____ oz total 24 hours

Solids/baby food? Y N Cereal ____ Vegetables ____ Fruit ____ Meat ___
Any problems feeding? Y N _____

Stool: regular irregular hard runny soft

Sleep problems: Y N _____

Development concerns: none speech motor social cognitive vision hearing

Does your baby:

Pull up to stand?	Y	N
Stand holding on?	Y	N
crawl?	Y	N
Pick up small item with fingers?	Y	N
Respond to name?	Y	N
Babble and jabber (baby talk)?	Y	N
Say “dada/mama” nonspecific?	Y	N
Wave byebye?	Y	N
Play “peekaboo”?	Y	N

Do you have any concerns about your baby? _____

_____