

9 TO 10 MONTH HEALTH QUESTIONNAIRE



This information is confidential.

Your answers help your physician or nurse practitioner choose the best topics to discuss with you at this visit. Skip any questions you don't understand or do not apply.

PHONE: _____

WHAT IS YOUR BABY LIKE THESE DAYS? DO YOU HAVE ANY QUESTIONS OR CONCERNS?

1. Do you feed your baby breastmilk? No Yes
2. Do you feed your baby infant formula with iron? No Yes
3. Do you feed your child cereal with iron or meat every day? No Yes
4. Does your baby drink any water with fluoride or take fluoride drops every day? No Yes
5. Do you always place your baby in a car seat facing backwards, in the back seat? No Yes
6. Do you keep all medications, house cleaning products, and poisons in a locked cabinet out of sight? No Yes
7. Do you have the poison control center phone number near your telephone? No Yes
8. Have you placed safety gates at the top and bottom of stairs? No Yes
9. Has your baby ever been a victim of abuse or violence? Yes No
10. Does your baby spend time in a home where anyone smokes? Yes No
11. Since your last well check, have there been any MAJOR illnesses, hospitalizations, surgeries, changes, or stresses for your family or baby? If yes, please list: Yes No
12. Please list any medications your baby is taking: _____
13. Does your baby receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? Yes No
14. Does your baby live in, or spend a lot of time in, a place built **before 1978** that has peeling or chipped paint or that has been **recently** renovated? Yes No
15. Does your child receive Medi-Cal or other government assistance (WIC)? Yes No
16. Has anyone who lives in your house or a baby sitter ever had a positive TB (Tuberculosis) skin test or active TB? Yes No
17. Were you (or any household members) born outside of the United States, or have you recently traveled to a developing country (Central or South America, Asia, or Africa)? Yes No
18. Has your child lived outside the U.S. for more than one month? Yes No
19. Does your baby sleep through the night? No Yes
20. Do you read to your baby every day? No Yes
21. Does your baby wave bye-bye? No Yes
22. Does your baby pull himself or herself up to standing? No Yes
23. Can your baby pick up things with thumb and pointer finger? No Yes
24. Does your baby babble? No Yes
25. Has your baby ever had a reaction to a vaccine (such as a high fever)? Yes No

CLINIC COUNSELING

- Questionnaire Reviewed
 - Pertinent Topics Discussed and Advice Given
- Sign: _____

Parent Signature: _____

Date: _____