WELL CHILD VISIT – AGE 9 MONTHS

☐ Male ☐ Female

Name: ______________________ ID # ______________ Age: _______ DOB: ____________ ☐ **IHEBAT** ☐ **120-Day IHA**

Accompanied by: ☐ Mom ☐ Dad ☐ Relative ☐ Other: __________ **Date of Visit:**_____________

Wt: lbs/oz/kg (%ile)	Ht: inches/cm (%ile)	HC: inches/cm (%ile)	Temp: F°/C°	Hgb :______ Bld Lead Level:_______ Nurse/MA________________

HISTORY

Interim History:

☐ No Problems
- ☐ Significant Illness / Injury _______________
- ☐ Medications: _______________________
- ☐ Allergies: _________________________
- ☐ Visits to other health care provider:
  (name) ___________________________________

Social / Family History:

☐ No interval changes
- ☐ Divorced / Single Parent
- ☐ Child care Type:___________________

Changes since last visit:_____________________

Nutrition: ☐ Breast ☐ Bottle ☐ Cup

Formula _______________ Oz/day ___________

Solid foods ______________________________

Juice ___________________________________

Water _________ Vitamins/Fluoride __________

Elimination: ☐ NL ___________________________

____

Sleep: ☐ NL _________________________________

____

Behavior: ☐ NL ______________________________

Toxic exposure: Lead ☐Yes ☐No Passive Smoking ☐Yes ☐ No

TB risk: ☐ High ☐ Low

DEVELOPMENTAL HISTORY
(✓ if within Normal Limits)

☐ Sits well, crawls, creeps or scoots
☐ Pulls to feet with support
☐ Feeds self with fingers
☐ Bangs objects together / Pokes with finger
☐ Responds to own name
☐ Understands a few words / Babbles / Imitates sounds
☐ Waves "bye-bye"
☐ Shakes, bangs, throws and drops objects
☐ Plays peek-a-boo or pat-a-cake
☐ May show anxiety with strangers

REFERRALS / AUTHORIZATIONS

☐ WIC ☐ Vision Referral
☐ CCS ☐ Dental Referral
☐ Counseling
☐ Specialist (name) ___________________________

PHYSICAL EXAM
(✓ if within Normal Limits)

NL		Comment if Abnormal
☐	General Appearance	
☐	Skin	
☐	Head	
☐	Eyes / Appears to see	
☐	Ears / Appears to hear	
☐	Nose	
☐	Mouth and Throat	
☐	Teeth	
☐	Neck	
☐	Lungs	
☐	Heart	
☐	Femoral Pulses	
☐	Abdomen	
☐	Genitalia	
☐	Ext/Hips	
☐	Back (Scoliosis)	
☐	Neurologic	

ASSESSMENT

☐ Well Child

ANTICIPATORY GUIDANCE / EDUCATION
(✓ if discussed or handout given)

☐ Breastfeed, iron-fortified formula
☐ Safe foods, finger foods, juice
☐ Drink from cup
☐ Supervise eating
☐ Sleep habits, bedtime routine
☐ Brush teeth, no bottle in bed
☐ Childproof home, poisons, electrical outlets, sharp objects
☐ Injury prevention, water, falls, burns, guns
☐ Family Relationships, sibling rivalry
☐ Exploration opportunities
☐ Car seats, smoke detectors
☐ No baby walkers
☐ Sunscreen
☐ Talk, sing, read, play music

IMMUNIZATIONS / LABORATORY

☐ DTaP ☐ IPV ☐ PCV ☐ Hct/Hgb
☐ Hib ☐ Hep B ☐ Lead Screen
☐ Other: ___________ ☐ __________
☐ Vaccine Information Statements (VIS) given to patient
☐ PPD Date given:_______________
Results: _______________
☐ CXR Results: _______________

Plan: 1. **NEXT VISIT AT AGE 12 Months** 10/03
2.
3.

Signature__________________________**MD/DO/NP/PA Date**:_________