ABC Pediatrics

Nine Month Pre-visit Questionnaire

Patient Name_____ Date_____

Bathes: (Daily) (Every other day)

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Formula: _____Ounces per feeding? _____ Every how many hours? ___

Solids: Cereals____ Rice____ Stage ____baby foods Table Foods_____

# of stools Daily_____# of voids Daily_____ # of hours sleeping at ONE time_____

Developmental Milestones (check all that apply)

- ☐ Stands holding on
- ☐ Bangs toys together
- ☐ Plays peek-a-boo
- ☐ Responds to name
- ☐ Walks holding on to furniture
- ☐ Imitates speech sounds
- ☐ Stands
- ☐ Looks for missing objects
- ☐ Stranger Anxiety
- ☐ Sits well
- ☐ Feeds Self
- ☐ Has thumb/finger grasp
- ☐ Goes to you to play or be comforted
- ☐ Pulls self to sitting position
- ☐ Says mama/dada
- ☐ Crawls
- ☐ Imitates speech
- ☐ Waves bye-bye
- ☐ Passes toys hand to hand
- ☐ Pulls self to standing position
- ☐ Passes things hand to hand

Any other concerns you would like to discuss?

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TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was your child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**
Lead Risk	**Does your child have a sibling or playmate that has had lead poisoning?**	**YES**	**NO**
	Does your child live in or regularly visit a home built before 1978 that being renovated?	**YES**	**NO**
	Does your child live in or regularly visit a house or childcare facility built before 1950?	**YES**	**NO**

Weight_____ Temp_____Height_____ Head Circumference_____