



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 _____

Type of water (bottled/well/city): _____ # of hours sleeping at ONE time _____

Developmental Milestones (check all that apply)

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

Any other concerns you would like to discuss?

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 _____