ABC Pediatrics         Nine Month Pre-visit Questionnaire         Patient Name       Date         Patient Name       Date         Bathes:       (Daily)         (Every other day)         Feeding Routine (circle one): Breast feeding Bottle Feeding Both         Formula:       Ounces per feeding?         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         Current daycare:	_
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Current daycare:	
Developmental Milestones (check all that apply)	
Stands holding on 🛛 Stranger Anxiety 🗆 Says mama/dada	
Bangs toys together   Sits well  Crawls	
Plays peek-a-boo $\Box$ Feeds Self $\Box$ Imitates speech	
Responds to name 🛛 Has thumb/finger grasp 🗆 Waves bye-bye	
Walks holding on to	
furniturecomforted $\Box$ Pulls self to standingImitates speech sounds $\Box$ Pulls self to sittingposition	3
Stands position	
Looks for missing objects	
Any other concerns you would like to discuss?	
Does your child have a sibling or playmate that has had lead poisoning? YES	NO
Risk Does your child live in or regularly visit a home built before 1978 that being YES	NO NO