8-9 Month Pre-Visit Questionnaire

Instructions: *Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.*

General Health

1	Do you have any concerns about your baby's health?	NO	YES
2	Has your baby had any problems with shots or immunizations?	NO	YES
3	Does your child receive health care from anyone besides a medical doctor (acupuncturist, herbalist, naturopath)?	NO	YES

Feeding/Nutrition

4	Is your baby breastfeeding?	YES, Very well	YES, OK	Not Well. I have questions/concerns
a	How many times a day does your baby breastfeed?			
5	Is your baby taking (drinking) formula?	YES, Very well	YES, OK	Not Well. I have questions/concerns
a	How many times a day does your baby take/drink formula?			
b	Which formula are you feeding your baby?			
6	Is your baby getting three meals of solid foods per day?	YES	NO	
7	Is your baby trying to feed him or herself?	YES	NO	
8	Can your baby drink from a sippy cup?	YES	NO	
9	Does your baby drink juice or other sweetened drinks?	NO	YES	
10	Do you give your baby any vitamins or supplements?	YES	NO	

Oral Health

11 Does your baby sleep with a bottle?	NO	YES
12 Does your baby breast or bottle-feed during the night?	NO	YES
13 Are you using a soft toothbrush or cloth with fluoridated toothpaste to clean your child's teeth and gums 2 times per day?	YES	NO
14 Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO

Elimination

15 Does your baby have any problems with bowel movements (going poop)?	NO	YES
16 Do you have any concerns about your baby's urination (peeing)?	NO	YES

Activity/Exercise/Screen time

17 Does your baby have screen time (smartphone, tablet, TV)?	NO	YES
18 Do you read to your baby every day?	YES	NO
19 Does your baby get supervised floor time every day?	YES	NO

Sleep

20 Does your baby sleep at least 6 to 8 hours without waking up at night?	YES	NO
21 Does your baby fall asleep on his/her own?	YES	NO
22 Do you have a bedtime routine?	YES	NO

Social Stressors

23 Do you feel that you receive the support you need?	YES	NO	
24 Have there been any major changes or stresses in your family recently?	NO	YES	
25 Within the past 12 months have you worried that your food would run out before you got money to buy more?	NO	YES	SOMETIMES
26 Within the past 12 months did you run out of food and you didn't have money to get more?	NO	YES	SOMETIMES
27 Do you have any worries or concerns about childcare?	NO	YES	
28 Has anyone ever hurt you or your baby?	NO	YES	

Development
(please refer to Ages and Stages Questionnaire)

Lead

Question		
29 Is your baby regularly in a house built before 1978?	NO	YES
a Is there any peeling or chipping paint?	NO	YES
b Has there been any recent or ongoing remodeling or do you plan to do any remodeling?	NO	YES
30 Does your baby have a brother, sister, or playmate who ever had lead poisoning?	NO	YES

Safety

Question		
31 Do you always stay close enough to touch your baby when he or she is in the bath?	YES	NO
32 Do you keep furniture away from windows or use window guards?	YES	NO
33 Does your baby wear any jewelry (including necklaces)?	NO	YES
34 Do you hold or carry hot liquids around the baby?	NO	YES
35 Does your baby ride in a rear-facing safety seat, in the back seat?	YES	NO
36 Does anyone smoke or vape around your baby?	NO	YES
37 Do you have working smoke and carbon monoxide detectors in your home?	YES	NO
38 Are you using a shade or sunscreen if your baby is in the sun more than 10 minutes?	YES	NO
39 Do you keep plastic bags and latex balloons away from your baby?	YES	NO
40 Is your water heater turned to below 120 degrees?	YES	NO
41 Do you have barriers around space heaters, wood stoves, etc.?	YES	NO
42 Are all of your household cleaners, chemicals, and medicines locked up?	YES	NO
43 Do you have the number for Poison Control?	YES	NO
44 Does your baby use a seated infant walker?	NO	YES
45 Is there a gun in the home?	NO	YES
a Is it locked or in a safe with the ammunition stored separately?	YES	NO

Tuberculosis

46 Has a family member or contact had tuberculosis disease (TB)?	NO	YES
47 Has a family member ever had a positive TB skin test (PPD)?	NO	YES
48 Was your baby born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
49 Has your baby traveled to a high-risk country for more than a week?	NO	YES

Review of Systems

50 Do you have any concerns about your baby's hearing?	NO	YES
51 Do you have any concerns about your baby's vision?	NO	YES
52 Does your baby ever look cross-eyed?	NO	YES