

Naval Hospital Oak Harbor Prime Health Center
Nine Month Well Child Visit

Date:

Time:

Provider Note

Interval History:

Past Medical History:

Medications:

Allergies:

Immunizations:

Family/Social History Update:

Development: Pulls to stand Turns to name Mama, dada, nonspecific
 Stranger anxiety Waves bye-bye Feeds self cracker

Physical Exam

Weight: _____ kg _____ lb _____ %ile
Length: _____ cm _____ in _____ %ile
OFC: _____ cm _____ in _____ %ile

Vital Signs N/A Pain: _____ (0-10)
Temp: _____ HR: _____
RR: _____ O2 Sat: _____

<u>Nl</u>	<u>Abn</u>	
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance:
<input type="checkbox"/>	<input type="checkbox"/>	Head:
<input type="checkbox"/>	<input type="checkbox"/>	Eyes:
<input type="checkbox"/>	<input type="checkbox"/>	ENT:
<input type="checkbox"/>	<input type="checkbox"/>	Neck:
<input type="checkbox"/>	<input type="checkbox"/>	Chest:
<input type="checkbox"/>	<input type="checkbox"/>	Heart:
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen:
<input type="checkbox"/>	<input type="checkbox"/>	Genitals:
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal:
<input type="checkbox"/>	<input type="checkbox"/>	Skin:
<input type="checkbox"/>	<input type="checkbox"/>	Neuro:

Assessment

Plan

Anticipatory Guidance
Immunizations: Influenza
Other:

Follow-up: 12 months of age other: _____

Addressograph

Examiner's Signature/Name Stamp

**Nine Month Well Child Visit
Parent Questionnaire**

1. Describe your baby's diet:
- Breastfeeds _____ times per day.
 - Formula feeds _____ ounces per day. Name of Formula: _____
 - Baby Foods
 - Table Foods
2. Baby's water source: City Well Bottled
3. Where does your baby sleep? Crib Parent's Bed Other:
4. Have you installed: Window Guards Stair Gate Kitchen Gate
5. Who is your baby's main caregiver?
6. Do you have any concerns about your baby's development? Yes/No
7. Are you aware of potential choking hazards (foods, coins, jewelry)? Yes/No
8. Does your baby drink from a cup? Yes/No
9. Are there any smokers in the household? Yes/No
10. Is there is a gun in the home? Yes/No
11. Des your home have working smoke detectors? Yes/No
12. Do you put the crib rails up whenever you leave your baby in its crib? Yes/No
13. Do you ever leave your baby alone on tables or beds? Yes/No
14. Do you ever leave your baby alone in the bathtub? Yes/No
15. Have you checked the temperature of the hot water where you live? Yes/No
16. Does your baby ride in a car seat in the back seat, facing backwards? Yes/No
17. Do you have a routine for putting your baby to sleep? Yes/No
18. Does your baby wear a pacifier or jewelry around his or her neck? Yes/No
19. Are you aware of the potential dangers of baby walkers? Yes/No
20. Do you fear for the safety of yourself or members of your family? Yes/No
21. What questions do you have for your baby's provider today? _____