Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

9 Month Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Do you have any concerns about any of the following for your baby? ..... Y N
   Eating Sleeping Vision Hearing
2. Circle the foods you've started:
   Cereal Fruits Veg. Meats Table foods
3. Has your baby had any reactions to any of the foods? ..... Y N
4. Has your baby had any injuries since last visit? ..... Y N
5. Is your child in daycare? ..... Y N

SAFETY

6. Do you always use a rear facing car seat positioned in the back seat? ..... Y N
7. Do you know infant CPR and first aid? ..... Y N
   (www.americanheart.org - search infant CPR Anytime)
8. Do you have the poison control phone number (1-800-222-1222)? ..... Y N
9. Does your child spend time with anyone that smokes? ..... Y N
10. Is there a gun in your home? ..... Y N
    If yes is it locked? ..... Y N
11. Do you put sunscreen on your baby? ..... Y N
12. Do you have any concerns regarding violence in your home? ..... Y N
13. Do you have any concerns regarding the use of alcohol or drugs by anyone caring for your child? ..... Y N

SOCIAL

14. Is parenting what you expected? ..... Y N
15. Do you have someone you can talk to when you are stressed? ..... Y N
16. Are there any new stresses or recent changes impacting your family (job change, move, divorce, illness)? ..... Y N

FAMILY MEDICAL HISTORY

17. Since your last visit has anyone in your child's extended family been diagnosed with a chronic illness (such as heart disease or diabetes)? ..... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date