

DATE \_\_\_\_\_

PATIENT NAME	DOB	SEX	PARENT NAME
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Allergies	Current Medications
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Prenatal/Family History

Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

**Interval History:**  
(Include injury/illness, visits to other health care providers, changes in family or home)

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**Nutrition**  
 Breast every \_\_\_\_\_ hours  
 Formula \_\_\_\_\_ oz every \_\_\_\_\_ hours  
 With iron  Y  N  
 Type or brand \_\_\_\_\_

City water  Well water  
 Solids  Y  N

**Elimination**  
 Normal  Abnormal

**Sleep**  
 Normal (8 hours)  Abnormal

Abnormal Findings and Comments  
 If yes, see additional note area on next page

**WIC**  Y  N

**Screening:**  
**Hearing**  
 Responds to voice & noise (parent report)  
 Responds to noisemaker (optional)  
 Parental observation/concerns

**Vision**  
 Fixes and follows  
 Parental observation/concerns

**Procedures**  
 Lead level \_\_\_\_\_ mcg/dl  
 Hct or Hgb \_\_\_\_\_ (required for Medicaid)  
 If Risk:  
 IPPD \_\_\_\_\_ (result)

**Immunizations:**  
 Immunizations Reviewed, Given & Charted –  
*if not given, document rationale*  
 DTaP  IPV  HepB  Hib  PCV  
 MCIR checked/updated  
 Acetaminophen \_\_\_\_\_ mg. q. 4 hours

**Next Well Check: 12 months of age**

**Developmental Questions and Observations on Page 2**

Provider Signature: \_\_\_\_\_

Patient Unclothed  Y  N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Abnormal Findings and Comments  
 If yes, see additional note area on next page

Results of visit discussed with parent  Y  N

**Plan**  
 History/Problem List/Meds Updated  
 Referrals  
 WIC  Early On  
 Children Special Health Care Needs  
 Transportation  
 Other \_\_\_\_\_  
 Other \_\_\_\_\_

**Anticipatory Guidance/Health Education**  
 (√ if discussed)

**Healthy and Safe Habits**  
**Injury and Illness Prevention**  
 Keep Poison Control number handy  
 Appropriate car seat placed in back seat  
 Pool/water safety  
 Know signs of illness/emergency procedures  
 Learn first aid/CPR  
 Water temp. <120 degrees  
 Childproof home - (hot liquids, cigarettes, alcohol, poisons, medicines, outlets, cords, small/sharp objects, plastic bags)  
 Crib Safety  
 Never shake baby  
 Limit time in sun/use hat & sunscreen on baby  
 Check home for lead poisoning hazards  
 Don't use baby walkers

**Nutrition**  
 Breastfeed or give iron-fortified formula  
 Encourage self-feeding, cup use  
 Supervise eating/ Avoid choking foods  
 Increase soft, moist table foods gradually

**Oral Health**  
 Don't put baby to bed with bottle  
 Discuss flouride  
 Brush baby's teeth with a soft toothbrush & water

**Parent-Infant Interaction**  
 Use words to set simple limits – don't yell or hit  
 Talk, sing, and read to baby; play games, music  
 Give same comfort object  
 Daily/Bedtime Routine (put baby to bed awake)  
 Safe Exploration Opportunities  
 Pat a Cake, Peek a Boo, So Big

**Family Support and Relationships**  
 Spend time alone with your partner  
 Keep in contact with friends, family  
 Discuss baby's explorations w/siblings  
 Family Planning  
 Chose responsible caregivers  
 Substance Abuse, Domestic Violence, Depression

**Community Interaction**  
 Discuss community resources  
 Discuss child care, work hours

## WELL CHILD EXAM-INFANCY: 9 Months

DATE	PATIENT NAME	DOB
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### Developmental Questions and Observations

Ask the parent to respond to the following statements about the infant:

Yes      No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Please tell me any concerns about the way your baby is behaving or developing |
| <hr/>                    |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby understands some words.   |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby shows feelings by smiling, crying and pointing.                       |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby says things like “da da” or “ba ba”.                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby can feed self with fingers.   |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby likes to be with me.  |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby is interested and explores new things.                                |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby is able to be happy, mad and sad.                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby can move around on his/her own.                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | My baby plays games like peek-a-boo or pat-a-cake.                            |

Ask the parent to respond to the following statements:

Yes      No

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | I am sad more often than I am happy.             |
| <input type="checkbox"/> | <input type="checkbox"/> | I have people who help me when I get frustrated. |
| <input type="checkbox"/> | <input type="checkbox"/> | I am enjoying my baby more days than not.        |
| <input type="checkbox"/> | <input type="checkbox"/> | I have a daily routine that seems to work.       |
| <input type="checkbox"/> | <input type="checkbox"/> | I keep in contact with family and friends.       |
| <input type="checkbox"/> | <input type="checkbox"/> | I feel safe with my partner.                     |

Provider to follow up as necessary

### Developmental Milestones

Always ask parents if they have concerns about development or behavior. (You may use the following screening list, or a standardized developmental instrument or screening tool).

Infant Development			Parent Development		
Responds to own name.	Yes	No	Shares baby’s smiles	Yes	No
Seeks parent/caregiver for reassurance	Yes	No	Talks to the baby in positive terms	Yes	No
Uses inferior pincer grasp	Yes	No	Touches the baby gently	Yes	No
Shows interest in things around them	Yes	No	Responsive, gentle and protective of the baby	Yes	No
Sits without support	Yes	No	Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. ( <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i> )		

**Additional Notes from pages 1 and 2:**

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Staff Signature: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

## Your Baby's Health at 9 Months

### Milestones

*Ways your baby is developing between 9 and 12 months of age.*

Stands up and moves holding onto furniture.

May start walking.

Points at things he/she wants.

Drinks from a cup and feeds himself/herself.

Plays games such as Pat-a-Cake and Peek-a-Boo.

Says 1-3 words (besides "mama," "dada").

Enjoys books.

Seeks parent for reassurance.

Is able to comfort self by sucking thumb or holding special toy or blanket.

Is able to be happy, mad and sad.

### For Help or More Information:

#### Breast feeding, food and health information:

- Women, Infant, and Children (WIC) Program, call 1-800-26-BIRTH.
- The National Women's Health Information Center Breastfeeding Helpline! Call with questions at 1-800-994-WOMAN (9662). Or visit the website at: <http://www.4woman.gov/breastfeeding>

#### Car seat safety:

Contact the Auto Safety Hotline at 1-888-327-4236.

#### For information about lead screening:

Contact the Michigan Department of Community Health Hotline at 1-800-648-6942.

#### Prevention of Unintentional childhood injuries:

National Safe Kids Campaign 1-202-662-0600 or [www.safekids.org](http://www.safekids.org)

#### For information about childhood development:

Contact EarlyOn Michigan at 1-800-327-5966 or the Michigan Head Start Associations at 1-517-374-6472.

#### For information about childhood immunizations:

Call the National Immunization Program Hotlines at 1-800-232-2522 (English) or 1-800-232-0233 (Spanish).

#### Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233)

### Health Tips:

Wash your hands often; especially after diaper changes and before you feed your baby. Wash your baby's toys with soap and water.

Add soft, moist table foods gradually (tuna, cooked mashed vegetables, spaghetti)

Let your baby drink some water, breast milk, or formula from a cup.

Keep soft bedding and stuffed toys out of the crib. Make sure your baby sleeps by him/herself in crib or portable crib.

Call your baby's doctor or nurse before your next visit if you have any questions or concerns about your baby's health, growth, or development.

Keep your baby's new teeth healthy. Clean them after feedings. Use the corner of a clean cloth or a tiny, soft toothbrush. Don't let your baby take a bottle to bed.

### Parenting Tips:

Read to your baby. Show your baby picture books and talk about the pictures. Sing songs and say nursery rhymes.

Make a safe environment at home to encourage baby to explore.

Babies develop in their own way. Your baby should keep learning and changing. If you think he/she is not developing well, talk to your doctor or nurse.

When you are a parent you will be happy, mad, sad, frustrated, angry and afraid, at times. This is normal. If you feel very mad or frustrated:

1. Make sure your child is in a safe place (like a crib) and walk away.
2. Call a good friend to talk about what you are feeling.
3. Call the free Parent Helpline at 1 800 942-4357 (in Michigan). They will not ask your name, and can offer helpful support and guidance. The helpline is open 24 hours a day. Calling does not make you weak; it makes you a good parent.

### Safety Tips

Always watch your baby in the bathtub. Drowning can happen quickly and silently in only a few inches of water. Take your baby with you if you have to leave the room.

Buckle up your baby in a car seat facing the rear of the car for the first year. Keep your baby in the back seat. It's the safest place for children to ride.