

# Well Child Exam

Infancy: 9 months



# 9 months

Date									
Patient Name				DOB		Sex		Parent Name	
Allergies					Current Medications				
Prenatal / Family History							Ethnicity		
Weight	Percentile	Length	Percentile	HC	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

<b>Interval History</b>
(include injury/illness, visits to other health care providers, changes in family or home)
_____
_____
<b>Nutrition</b>
<input type="checkbox"/> Breast every _____ hours
<input type="checkbox"/> Formula _____ oz. every _____ hours W/iron Y <input type="checkbox"/> N <input type="checkbox"/>
Type or brand _____
<input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Fluoride Rx
<input type="checkbox"/> Solids Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Elimination</b>
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Sleep</b>
<input type="checkbox"/> Normal (8 hours) <input type="checkbox"/> Abnormal
<input type="checkbox"/> Abnormal Findings and Comments
If yes, see additional note area on next page
<b>Screening</b>
<b>Hearing</b>
<input type="checkbox"/> Responds to voice & noise (parent report)
<input type="checkbox"/> Responds to noisemaker (optional)
<input type="checkbox"/> Parental observation/concerns
<input type="checkbox"/> <b>Vision</b>
<input type="checkbox"/> Fixes and follows
<input type="checkbox"/> Parental observation/concerns
<b>Lead Poisoning</b>
Test date _____ <input type="checkbox"/> Lead level _____ mcg/dl
<input type="checkbox"/> Hct or Hgb _____ (required for Medicaid)
If Risk: <input type="checkbox"/> IPPD _____ (result)
<b>Immunizations</b>
<input type="checkbox"/> Immunizations Reviewed, Given & Charted – if not given, document rationale
<input type="checkbox"/> DTaP <input type="checkbox"/> IPV <input type="checkbox"/> HepB <input type="checkbox"/> Hib <input type="checkbox"/> PCV
<input type="checkbox"/> MCLR checked/updated <input type="checkbox"/> VIS given
<input type="checkbox"/> Acetaminophen _____ mg. q. 4 hours
WIC <input type="checkbox"/> Y <input type="checkbox"/> N
<b>Developmental Questions and Observations on Page 2</b>
<b>Next Well Check: 12 months of age</b>
Provider Signature:

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N				
<b>Review of Symptoms</b>		<b>Physical Exam</b>		<b>Systems</b>
<b>N</b>	<b>A</b>	<b>N</b>	<b>A</b>	
<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/rash
<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
<input type="checkbox"/> Abnormal Findings and Comments				
If yes, see additional note area on next page				
Results of visit discussed with parent <input type="checkbox"/> Y <input type="checkbox"/> N				
Plan				
<input type="checkbox"/> History/Problem List/Meds Updated				
<input type="checkbox"/> Referrals				
<input type="checkbox"/> WIC <input type="checkbox"/> Early On <input type="checkbox"/> Transportation				
<input type="checkbox"/> Children Special Health Care Needs				
<input type="checkbox"/> Priority Health Case Mgmt 800 998-1037				
<input type="checkbox"/> Other _____				

<b>Anticipatory Guidance / Health Education</b> (√ if discussed)
<b>Healthy and Safe Habits</b>
<b>Injury and Illness Prevention</b>
<input type="checkbox"/> Keep home and car smoke-free
<input type="checkbox"/> Keep Poison Control number handy
<input type="checkbox"/> Appropriate car seat placed in back seat
<input type="checkbox"/> Pool/water safety
<input type="checkbox"/> Know signs of illness/emergency procedures, learn first aid/CPR
<input type="checkbox"/> Water temp. <120 degrees
<input type="checkbox"/> Childproof home - (hot liquids, cigarettes, alcohol, poisons, medicines, outlets, cords, small/share objects, plastic bags)
<input type="checkbox"/> Crib Safety
<input type="checkbox"/> Never shake baby
<input type="checkbox"/> Limit time in sun/use hat & sunscreen
<input type="checkbox"/> Check home for lead poisoning hazards
<input type="checkbox"/> Don't use baby walkers
<b>Nutrition</b>
<input type="checkbox"/> Breastfeed or give iron-fortified formula
<input type="checkbox"/> Encourage self-feeding, cup use
<input type="checkbox"/> Supervise eating/ Avoid choking foods
<input type="checkbox"/> Increase soft, moist table foods gradually
<b>Oral Health</b>
<input type="checkbox"/> Don't put baby to bed with bottle
<input type="checkbox"/> Discuss fluoride
<input type="checkbox"/> Brush baby's teeth with a soft toothbrush & water
<b>Parent-Infant Interaction</b>
<input type="checkbox"/> Use words to set simple limits – don't yell or hit
<input type="checkbox"/> Talk, sing, and read to baby; play games, music
<input type="checkbox"/> Give same comfort object
<input type="checkbox"/> Daily/bedtime routine (put baby to bed awake)
<input type="checkbox"/> Safe exploration opportunities
<input type="checkbox"/> Pat a Cake, Peek a Boo, So Big
<b>Family Support and Relationships</b>
<input type="checkbox"/> Spend time alone with your partner
<input type="checkbox"/> Keep in contact with friends, family
<input type="checkbox"/> Discuss baby's explorations w/siblings
<input type="checkbox"/> Family planning
<input type="checkbox"/> Chose responsible caregivers
<input type="checkbox"/> Substance abuse, domestic violence, depression
<b>Community Interaction</b>
<input type="checkbox"/> Discuss community resources
<input type="checkbox"/> Discuss child care, work hours

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

      Please tell me any concerns you have about the way your baby is behaving or developing:

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- My baby understands some words.
  - My baby shows feelings by smiling, crying, and pointing.
  - My baby says things like "da da" or "ba ba".
  - My baby can feed self with fingers.
  - My baby likes to be with me.
  - My baby is interested and explores new things.
  - My baby is able to be happy, mad and sad.
  - My baby can move around on his/her own.
  - My baby plays games like peek-a-boo or pat-a-cake.

Ask the parent to respond to the following statements:

Yes      No

- I am sad more often than I am happy.
- I have people who help me when I get frustrated.
- I am enjoying my baby more days than not.
- I have a daily routine that seems to work.
- I keep in contact with family and friends.
- 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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### Family History Update

Since your last visit, have there been any changes in your family history? Include:

- Deaths: who \_\_\_\_\_ what age \_\_\_\_\_
- New medical diagnosis: who \_\_\_\_\_ what age \_\_\_\_\_
- Anything else in your family history you have concerns or questions with: (Refer to Family History form)

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

## Patient Education:

### Your Baby's Health at 9 months

#### Milestones: Ways your baby is developing between 9 and 12 months

- Stands up and moves holding on to furniture, may start walking
- Points at things he/she wants
- Drinks from a cup and feeds himself/herself
- Plays games (Pat-a-Cake, Peek-a-Boo), enjoys books
- Says 1-3 words (besides "mama," "dada")
- 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

#### 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.

#### 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 using the corner of a clean cloth or a tiny, soft toothbrush. Don't let your baby take a bottle to bed.
- Be sure to schedule your baby's well-child visits at 12 & 15 months of age.
- Ask your doctor to test your child for lead poisoning at 12 & 24 months of age.

#### 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:
  - o Make sure your child is in a safe place (like a crib) and walk away.
  - o Call a good friend to talk about what you are feeling.
  - o Call the Parent Helpline at 800 942-4357 (in Michigan). It's free! 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.

## For Help or More Information

### **Priority Health**

Customer Service 616 942-1221 or 800 446-5674

Medicaid 888 975-8102

Behavioral Health 616 464-8500 or 800 673-8043

*priorityhealth.com*

### **Depression**

Surrounding pregnancy and childbirth

*www.depressionafterdelivery.com/Home.asp*

### **Domestic Violence**

National Domestic Violence Hotline

800 799-SAFE (7233)

### **Breastfeeding, Food and Health Information:**

Women, Infant, and Children (WIC) Program,

800 262-4784

The National Women's Health Information Center Breastfeeding Helpline

800 994-WOMAN (9662) *www.4woman.gov/breastfeeding*

LA LECHE League 847 519-7730 *www.lalecheleague.org*

### **Special Health Care Needs**

Children Special Health Care Services, MDCH Family 800 359-3722

### **Car Seat Safety**

Auto Safety Hotline 888 327-4236.

### **Childhood Development**

Early On Michigan 800 327-5966

Michigan Head Start Association 517 374-6472

### **Childhood Immunizations**

National Immunization Program Hotlines

800 232-2522 (English) or 800 232-0233 (Spanish)

### **Childcare**

Child Care Licensing Agency, Michigan Department of Consumer & Industry Services

517 373-8300

### **Lead Screening**

Michigan Department of Community Health Hotline

800 648-6942