California Pediatrics
Come grow with us

9 Month Well Exam

Name
Room
Notes

Weight	T
Length	HR
OFC	RR
	O2

Nutrition

What type of milk does your baby drink?	Breast Milk	Formula			
Does your baby take any vitamins?	Yes	No			
Which solids does your baby eat?	Grains/Cereal	Veggies	Fruits	Proteins	Table Food
Does your baby eat honey?	No	Yes			

Dental

Do you brush your baby's teeth?	Yes	No

Sleep

Does your baby sleep through the night?	Yes	No
How many naps does your baby take per day?	2 or more	<2

Development

Do you feel that your baby sees well?	Yes	No
Do you feel that your baby hears well?	Yes	No
Does your baby say 'da', 'ma', or 'ba'?	Yes	No
Does your baby use the thumb and forefinger to pick up food ?	Yes	No
Does your baby crawl and/or cruise?	Yes	No
Does your baby wave 'bye-bye'?	Yes	No
Is your baby shy with strangers?	Yes	No
Do you read to your baby?	Yes	No

Safety

Have you babyproofed your home?	Yes	No
Do you use a rear-facing carseat for your baby?	Yes	No
Any smokers at home?	No	Yes

Followup D/W/M
Reason:

□EHR