9 Month Well Exam

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A WellCare Company

Date_____ Patient #_____

Name_____ Date of Birth_____

Address_____

_____

Lives with: ☐ 1 Parent ☐ 2 Parents ☐ Other Caregiver

☐ Others (including siblings)_____

_____

May release information to (parent, guardian, other family - list):

_____

_____

Parental concerns: _____

_____

Changes in child's health since last visit:_____

_____

GENERAL HEALTH

Nutrition: ☐ Breast:_____times/day
☐ Bottle:_____ oz/day

YES	NO	
☐	☐	Drink from a cup?
☐	☐	Juice: _____oz/day
☐	☐	Table/finger foods?

Solids: ☐ Cereals ☐ Fruits ☐ Vegetables ☐ Meats

Daily oral health care? ☐ Yes ☐ No ☐ No Teeth
☐ Dental visit?

Elimination: ☐ Stooling: soft, easy to pass BMs

Sleep:_____hours through the night

YES	NO	
☐	☐	Problems? Night feedings?_____
☐	☐	Bottle to bed?

DEVELOPMENT (Screen or refer if concerns or "No" response on milestones in **bold type)**

YES	NO	
☐	☐	**Interacts with family by smiling and vocalizing**
☐	☐	Expresses emotions
☐	☐	Waves "bye-bye" or plays "pat-a-cake"
☐	☐	**Babbles, repeats syllables like ba-ba, na-na**
☐	☐	**Imitates sounds**
☐	☐	**Transfers object to other hand**
☐	☐	**Feeds self cracker**
☐	☐	May pick up Cheerio
☐	☐	**Sits well without support**
☐	☐	Stands holding on to stable object

Family concerns about growth, development, behavior

_____

_____

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care:_____

FAMILY RISK FACTORS

Changes in family since last visit:_____

_____

STRESS:

How much stress are you and your family under now?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

What kind of stress?
☐ Relationship ☐ Alcohol ☐ Drugs
☐ Violence/Abuse ☐ Lack of help ☐ Financial
☐ Health Insurance ☐ Child care
☐ Other_____

How stressful is caring for your child?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless?
☐ No ☐ Sometimes ☐ **Often**

In the past month, have you/partner felt little interest or pleasure in doing things?
☐ No ☐ Sometimes ☐ **Often**

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:

☐ Discuss support system/childcare/community resources

BEHAVIOR:

☐ Sleep routines. Lower mattress in crib - may stand or climb
☐ Emerging independence and separation anxiety
☐ Learning cause/effect
☐ Continue to read, sing and play with child
☐ Allow child to safely explore environment - with supervision!

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

☐ Safe finger foods. Exposure to new tastes and textures
☐ 3 meals, 2-3 snacks a day
☐ Eat with family at table (secure seating)
☐ Increase cup use, decrease bottle
☐ Smear of fluoride-containing toothpaste and soft toothbrush

SAFETY:

☐ No poisons under kitchen sink. Discuss wading pools and guns
☐ Barriers around heat sources, windows and stairs
☐ Electrical outlet covers
☐ Remove choking hazards, tablecloths
☐ Rear-facing car seat until 1 year **and** 20 lbs. Always in back seat
☐ Poison control: **800-222-1222**
☐ If smoking in home: discuss quitting, limiting exposure

Revised June 2012

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MEDICAL HISTORY

Name _____ Date of Birth _____

Allergies _____ Medications _____

Major medical illnesses/special healthcare needs _____

Hospitalizations/Surgeries _____

PHYSICAL EXAMINATION (UNCLOTHED)

☐ Vision Evaluation
☐ Hearing Evaluation

Vital Signs: P:_____R:_____T:_____Weight:_____(_____%)

Length _____(_____%) Wt/Length _____% Head circumference _____(_____%)

Review of Systems

N	Abn	N	Abn		*Comment on abnormal findings*
☐	☐	☐	☐	General appearance	
☐	☐	☐	☐	Behavior/interaction with family	
☐	☐	☐	☐	Skin	
☐	☐	☐	☐	Head/scalp	
☐	☐	☐	☐	Ears	
☐	☐	☐	☐	Eyes	
☐	☐	☐	☐	Nose	
☐	☐	☐	☐	Mouth/throat	
☐	☐	☐	☐	Teeth	
☐	☐	☐	☐	Neck	
☐	☐	☐	☐	Back/chest	
☐	☐	☐	☐	Lungs	
☐	☐	☐	☐	Heart	
☐	☐	☐	☐	Abdomen	
☐	☐	☐	☐	Genitalia	
☐	☐	☐	☐	Musculoskeletal	
☐	☐	☐	☐	Neurological	

Results reviewed (outside info, lab, etc.) _____

Impression _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent

Past adverse reaction to immunizations: ☐ Yes ☐ No

☐ Vaccines given ☐ Vaccines refused _____

Lab (if indicated) _____

Developmental follow-up ☐ No delays ☐ Follow-up in office ☐ Referral

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated) _____

Handouts _____

Return appointment _____

Signature _____ Date _____

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