Iowa Child Health and Development Record

9 month Well Exam

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	
❑	❑	Drinking from cup?
❑	❑	Table/finger foods?

Solids: ❑ Cereals ❑ Fruits ❑ Vegetables ❑ Meats

❑ Juice ____oz/day

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 development or behavior?

_____

MEDICAL HISTORY:

Allergies:_____ Meds:_____

Major medical illnesses/special health care needs:_____

_____

Hospitalizations:_____

Surgeries:_____

FAMILY HISTORY:

❑ Reviewed and updated

SOCIAL HISTORY:

Childcare: _____

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? ❑ Relationships ❑ Drugs ❑ Alcohol
❑ 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.
❑ Allow child to safely explore environment – supervision!
❑ Continue to read, sing, and play with child.
❑ No TV, videos.
❑ Thoughts about discipline? Family agreement?
❑ Recommend consistency and distraction

NUTRITION / OBESITY PREVENTION / ORAL HEALTH

❑ Safe finger foods. Exposure to new tastes & 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
❑ Refer to dental home within 6 mos of first tooth.

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 pounds. Always in back.
❑ Poison control #: 1-800-222-1222
❑ If smoking in home: discuss quitting, limiting exposure

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PHYSICAL EXAMINATION

Vital signs: P: _____R: _____T: _____ Weight_____(_____%)

Length_____(_____%) Wt/Length_____% Head circumference_____(_____%)

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_____

❑ ❑ Neurologic _____

❑ ❑ Developmental Screening (ASQ, other) _____

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

Impression:_____

_____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations: ❑ Vaccine Information Statements offered to parent
Past adverse reactions to immunizations: ❑ No ❑ Yes
See current guidelines www. immunize.org/aap

LAB: ❑ Lead if high risk ❑ (if indicated)_____

Developmental Follow-up ❑ No delays ❑ Follow-up in office ❑ Referral

Referral: (if indicated)_____

Central referral numbers: For assistance with care coordination, transportation, or health information for children ***birth through age 21:***
Healthy Families Line 1-800-369-2229
For referral of children ***birth to age 3*** with developmental delay to local Early Access providers:
Early Access Line 1-888-425-4371

Handouts:_____

Return appointment:_____

Signature _____ Date _____