**MUNDELEIN PEDIATRICS**

**9 Month Well Exam**

Name: ________________________________________DOB: ____/____/____ Today's Date: ____/____/____

*Please circle the answer that most appropriately describes your child:*

1. Breastfeeding: Yes/No Concerns: ___________________________
2. Formula feeding: Yes/No Concerns: ___________________________
3. Solids (rice cereal/pureed fruits or vegetables, finger foods) Yes/No Concerns: ___________________________
4. Sleeps through the night: Yes/No Concerns: ___________________________
   (____) hours per night
   (____) hours from naps during the day
5. Excessive spitting or vomiting: Yes/No Concerns: ___________________________
6. Urinating well: Yes/No Concerns: ___________________________
7. Normal bowel movements: Yes/No Concerns: ___________________________
8. Sleeps on back: Yes/No Concerns: ___________________________
9. Rides in a rear-facing car seat in the back seat: Yes/No
10. Takes vitamins: Yes/No Product Name: _______________________
11. Emergency room visits: Yes/No
12. Illness since last visit: ________________________________________________________________

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*Please circle the answer that most appropriately describes your home environment:*

1. Smoke-free home and car: Yes/No
2. Parent smokes outside: Yes/No Mom/Dad/Sibling/Relative/Babysitter
3. Daycare: None/Relative/Center/Babysitter
4. Primary care taker: Mom/Dad/Grandparents
5. Household composition:
   Adult(Names/Ages): ____________________________________________________________
   Children(Names/Ages): _________________________________________________________
6. New health problems in parents or siblings: ______________________________________________
7. Past vaccine reactions: Yes/No
8. Sibling rivalry: Yes/No

*Do you have any other concerns you wish to discuss?* Yes/No

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