9 MONTH OLD

NAME _____
DATE _____

pediatrics NORTHWEST PS Mary Bridge Children's

www.pedsnw.net

MEDICAL HISTORY

Select Has your child had any reactions to medications or immunizations?
Select Does your child take any medications (daily or as needed)?
Select Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
Select Are there any major illnesses in the family? Which ones? _____
Select Are there any major changes or stresses in the family (moves, deaths, separation, etc)?
Select Is your child in day care?
Select Has your child ever been diagnosed with an immunodeficiency?
Select Has your child had any illnesses, hospitalizations, or surgeries that we are not already aware of?

NUTRITION

Select Is your baby breastfed?
Select Does your baby take a bottle?
Select Have you introduced any other foods? (water, juice, baby foods, infant cereal, finger foods, etc)

PREVENTIVE HEALTH

Select Does your child always ride in a car seat and in the backseat?
Select Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
Select Have those alarms been checked in the past 12 months?
Select Does your child live with anyone who smokes?
_____ How many hours of "screen time" (TV, movies, video games etc) is your child around per day?

REVIEW OF SYSTEMS *(Does your child have any current problems with the following?)*

Select eyes (crossing, not focusing, drainage, inflammation, etc)
Select swallowing or eating
Select coughing, breathing, shortness of breath, wheezing, or turning blue
Select vomiting
Select stooling (diarrhea, constipation, or blood in the stools)
Select urination (change in frequency, or blood in the urine)
Select extremities (feet, legs, arms, hands)

Please name several activities you enjoy doing with your child:

CONCERNS

Select Do you have any special concerns today?

Thanks for filling out this form.