9 MONTH OLD

"After exploring, I may just need to be next to you to recharge and feel calm again."

pediatrics NORTHWEST PS Mary Bridge Children's

www.pedsnw.net

Patient Name: _____

Person Filling Out Form: _____

Relationship to Patient: _____

CONCERNS

yes no Do you have any questions or concerns about your child's health, development, or behavior?

MEDICAL HISTORY

yes no Does your child take any medications (daily or as needed)? If so, please list: _____
yes no Has your child had any reactions to medications?
yes no Is your child currently taking any vitamins, supplements, "alternative medicines" or therapies?
yes no Are there any major changes or stresses in the family (moves, deaths, separation, etc.)?
yes no Is your child in day care?
yes no Has your child had any new illnesses, ER visits, hospitalizations, or surgeries since their last visit?
yes no Has a parent or household member ever had a problem with alcohol or drug use?
yes no Is there any new information to add to family medical history since the last well child visit?

NUTRITION

yes no Is your baby breastfeeding?
yes no Does your baby take a bottle? If so, what and how much? _____
yes no Have you introduced any other foods or liquids? If so, what? _____

PREVENTIVE HEALTH

yes no Does your child sleep with a bottle, blanket or pillow in the crib?
yes no Does your child always ride in a rear facing car seat and in the backseat?
yes no Does your child live with anyone who smokes, vapes, or uses e-cigarettes?
yes no Are there smoke alarms, fire extinguishers and carbon monoxide alarms in your home?
yes no Have those alarms been checked in the past 12 months?
yes no N/A If you own firearms, are they always locked up and ammunition stored separately?
yes no Is your child enrolled in WIC?

On average, how difficult was it for your family to meet expenses for basic needs like food, housing, and/or utilities in the past year? (Please circle one that most applies):

Never Seldom Some of the time Most of the time

REVIEW OF SYSTEMS *(CIRCLE ANY **CURRENT** CONCERNS YOU WOULD LIKE TO DISCUSS TODAY)*

yes no Eyes (crossing, not focusing, drainage, redness)
yes no Swallowing or eating
yes no Coughing, noisy or difficulty breathing, or turning blue
yes no Vomiting
yes no Stooling (diarrhea, constipation, or blood in the stools)
yes no Extremities (feet, legs, arms, hands)

Thank you for filling out this form.

Revised 6/2021