

9 MONTH WELL CHECK-UP

NAME _____ DATE _____ DOB _____

Caregiver concerns: _____

Daily Activities

Crawls _____
Explores _____
Sleep _____
Other _____

Feeding

Formula or breast _____
How much _____
How often _____
Total amount per day _____
Other foods _____

Stools

Number _____
Color _____
Consistency _____
Constipation _____

Development

Says mama or dada _____
Likes games _____
Imitates sounds _____
Creeps or crawls _____
Feeds self foods _____
Pulls to stand _____
Starts to explore _____

Physical Exam

Please use growth chart

Hgt _____ % _____
Wgt _____ % _____
H.C. _____ % _____

HEENT _____

Neck _____

Lungs _____

Heart _____

Abdomen _____

GU _____

Ortho _____

Neuro _____

Skin _____

Impression

Plan

Denver
Hepatitis B #3 (if not given on 6 month check up)

Topics Discussed

- | | |
|---|----------------------------|
| 1. Safety latches on cupboards _____ | 4. Poison prevention _____ |
| 2. Increase drinking from cup; try to wean
from bottle by one year _____ | 5. Other _____ |
| 3. Encourage table foods _____ | _____ |

Return to office _____