Pre-Visit Questionnaire
9 month Visit

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today? ______________________

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Questions about your child.

Have any of your child's relatives developed new medical problems since your last visit?

❑ Yes ❑ No ❑ Unsure If yes, please explain: ______________________

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	Question			
Hearing	Do you have any concerns about how your child hears?	❑ Yes	❑ No	❑ Unsure
Vision	Do you have concerns about how your child sees?	❑ Yes	❑ No	❑ Unsure
Vision	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	❑ Yes	❑ No	❑ Unsure
Vision	Is there a family history of strabismis (eye crossing or lazy eye)?	❑ Yes	❑ No	❑ Unsure
Vision	Do your child's eyelids droop or does one eyelid tend to close?	❑ Yes	❑ No	❑ Unsure
Vision	Have your child's eyes ever been injured?	❑ Yes	❑ No	❑ Unsure
LEAD	Does your child have a sibling or playmate that has had lead poisoning?	❑ Yes	❑ No	❑ Unsure
LEAD	Does you child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	❑ Yes	❑ No	❑ Unsure
LEAD	Does your child live in or regularly visit a house or child care facility built before 1950?	❑ Yes	❑ No	❑ Unsure
Oral Health	Are cavities a problem for you or anyone else in your family?	❑ Yes	❑ No	❑ Unsure
Oral Health	Does your child sleep with a bottle?	❑ Yes	❑ No	❑ Unsure
Oral Health	Does your child continuously breastfeed through the night?	❑ Yes	❑ No	❑ Unsure

Have there been any major changes in your family lately? ❑ No ❑ Yes

❑ *Move* ❑ *Separation* ❑ *Divorce* ❑ *Death in the family* ❑ *Job change* ❑ *Other* ______________________

* Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ❑ Yes ❑ No

Does your child have any special health care needs? ❑ Yes ❑ No If yes, please explain: ______________________

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* List your child's current medications and doses: Include any herbs, vitamins or supplements: ______________________

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* What is the best way to contact you (please circle): home phone / cell phone / work phone: ______________________

* Would you like to share your email address? ______________________