9 to 10 Month
Well Check Questionnaire

Please answer these questions about your child.
Skip any questions that you cannot answer or that do not apply.
Your answers will help us provide you and your child with the best possible care.

Do you have any questions or concerns that you would like to discuss with your doctor? . . . . . ☐ **Yes** ☐ **No**
If yes, please describe: _____

NUTRITION

1. What does your child eat? . . . ☐ **Only breast milk** ☐ **Some breast milk, some formula** ☐ **Only formula**
2. Does your child drink cow's milk? . . . . . ☐ **Yes** ☐ **No**
3. Do you offer solid foods? . . . . . ☐ **No** ☐ **Yes**
4. Do you feed your child iron-rich foods (such as pureed meat, iron-fortified cereal, or beans)? . . . . . ☐ **No** ☐ **Yes**

If your child is breastfeeding: *[If your child is **not** breastfeeding, please skip to* **DENTAL HEALTH***.]*

5. Do you give your child vitamin D drops? . . . . . ☐ **No** ☐ **Yes**

DENTAL HEALTH

6. Do you give your child a bottle with anything in it except formula, milk, or water? . . . . . ☐ **Yes** ☐ **No**
7. Do you brush your child's teeth with a tiny smear of fluoride toothpaste every day? . . . . . ☐ **No** ☐ **Yes**

TUBERCULOSIS

8. Has your child had close contact with anyone who has tuberculosis (TB) or who has had a positive TB skin test? . . . . . ☐ **Yes** ☐ **No**
9. Was your child born in a country at high risk for tuberculosis (including countries in South America, Central America, Africa, Asia [except Japan], Eastern Europe, Russia, and surrounding areas), or has anyone in your household (including your child) traveled to one of these countries? . . . . . ☐ **Yes** ☐ **No**

SAFETY

10. Do you always put your child to sleep on his or her back? . . . . . ☐ **No** ☐ **Yes**
11. Do you place your child in a rear-facing car seat in the backseat for every car ride? . . . . . ☐ **No** ☐ **Yes**
12. If your home has more than one floor, do you have safety guards on the windows and gates for the stairs? . . . . . ☐ **No** ☐ **Yes**
13. Do you know what to do if your child is choking? . . . . . ☐ **No** ☐ **Yes**
14. Do you stay with your child at all times around water (such as in the bathtub and around pools, ponds, and buckets)? . . . . . ☐ **No** ☐ **Yes**
15. Does your child live in, or spend lots of time in, a place built before 1978 that has peeling or chipped paint or that has been recently renovated? . . . . . ☐ **Yes** ☐ **No**

YOUR GROWING CHILD

16. Does your child get into a sitting position by himself or herself? ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**
17. Does your child pick up food and eat it? . . . . . ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**
18. Does your child pull up to standing? . . . . . ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**
19. Does your child copy sounds that you make? . . . . . ☐ **Not yet** ☐ **Somewhat** ☐ **Yes, often**

FAMILY LIFE

20. Does your child watch TV or movies, or play games on a phone or tablet? . . . . . ☐ **Yes** ☐ **No**
21. Since your child's last checkup, has your family or child experienced any major issues (such as illness, move, job change or loss, separation or divorce, death in the family)? . . . . . ☐ **Yes** ☐ **No**
    If yes, please list: _____

For mother of child:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

22. Little interest or pleasure in doing things?
    ☐ **Not at all** ☐ **Several days** ☐ **More than half the days** ☐ **Nearly every day**
23. Feeling down, depressed, or hopeless?
    ☐ **Not at all** ☐ **Several days** ☐ **More than half the days** ☐ **Nearly every day**

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KAISER PERMANENTE®

9至10個月
健康核查問卷

請回答以下有關您孩子的問題。
請跳過任何您無法回答或不適用的問題。
您的回答將幫助我們為您和孩子提供最佳護理。

您有任何疑問或顧慮想要咨詢醫生嗎？ ☐ 是 ☐ 否
如果回答「是」，請說明：_____

營養

1. 您給孩子吃什麼？ ☐ 僅母乳 ☐ 部分母乳，部分奶粉 ☐ 僅奶粉
2. 您的孩子喝牛奶嗎？ ☐ 是 ☐ 否
3. 您給孩子餵食固體食物嗎？ ☐ 否 ☐ 是
4. 您給孩子吃富含鐵質的食物嗎（例如絞碎肉類、鐵強化穀麥片或豆類）？ ☐ 否 ☐ 是

如果您的孩子喝母乳： *[如果您的孩子現在**不**喝母乳，請直接跳至「**牙齒健康**」。]*

5. 您給孩子服用維生素D滴劑嗎？ ☐ 否 ☐ 是

牙齒健康

6. 除裝有沖泡奶粉、牛奶或水的奶瓶外,您還會給孩子裝有其他東西的奶瓶嗎？ ☐ 是 ☐ 否
7. 您每天用少量含氟牙膏幫孩子刷牙嗎？ ☐ 否 ☐ 是

結核病

8. 您的孩子曾經和任何結核病 (TB) 患者或結核病皮膚測試呈陽性的人有過近距離接觸嗎？ ☐ 是 ☐ 否
9. 您的孩子是否出生在結核病高風險國家（包括中南美洲、非洲、亞洲 [日本除外]、東歐國家、俄羅斯及周邊地區），或者您家裡是否有人（包括您的孩子）曾到過這些國家或地區？ ☐ 是 ☐ 否

安全

10. 您總是讓孩子仰睡嗎？ ☐ 否 ☐ 是
11. 您每次開車帶孩子出門時，是否讓孩子坐在後座的兒童安全座椅上，面朝後方？ ☐ 否 ☐ 是
12. 如果您家不只一層樓，那麼窗戶是否有安全鎖，樓梯是否有柵門？ ☐ 否 ☐ 是
13. 您知道萬一孩子哽噎該怎麼辦嗎？ ☐ 否 ☐ 是
14. 當您的孩子靠近水邊時（例如浴缸裡或泳池、池塘或水桶邊），您是否一直在旁看護？ ☐ 否 ☐ 是
15. 您的孩子是否居住或長時間待在1978年以前修建，且油漆剝落或碎裂，或是剛裝修好的房子里？ ☐ 是 ☐ 否

成長中的孩子

16. 您的孩子可以獨自坐立嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常
17. 您的孩子會把食物拿起來吃嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常
18. 您的孩子可以被拉著站起來嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常
19. 您的孩子會模仿您發出的聲音嗎？ ☐ 還不會 ☐ 稍微 ☐ 是，經常

家庭生活

20. 您的孩子會看電視或影片，或者玩手機或平板電腦上的遊戲嗎？ ☐ 是 ☐ 否
21. 從孩子上一次檢查至今，您的家人或孩子是否經歷任何重大變故（例如生病、搬家、換工作或失業、分居或離婚、家人去世）？ ☐ 是 ☐ 否
如果回答「是」，請列示：_____

由孩子的母親回答：

過去2週以來，您受以下任何問題困擾的頻率是？

22. 做事失去興致或樂趣？ ☐ 完全不會 ☐ 有幾天 ☐ 一半時間以上 ☐ 幾乎每天
23. 感覺心情低落、抑鬱或無望？ ☐ 完全不會 ☐ 有幾天 ☐ 一半時間以上 ☐ 幾乎每天

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