Well Baby Check: 6 month visit questionnaire

Interval History:
Has your baby had any major illnesses, ER or Urgent Care trips since your last appointment in the office?  
   No  Yes
Has your baby had any reactions to vaccinations in the past?  
   No  Yes

Development:
Can your baby pass objects from one hand to the other?  
   Yes  No
Does your baby grasp objects and put them near his/her mouth?  
   Yes  No
Can your baby focus on/see small objects?  
   Yes  No
Does your baby turn to your voice?  
   Yes  No
Do you have any concerns about how your baby sees or hears?  
   No  Yes
Do your baby’s eyes move together (no crossing)?  
   Yes  No
Does your baby babble consonants (e.g. “ba,” “ma,” or “ga”)?  
   Yes  No
Can your baby sit with support (minimal help from adult)?  
   Yes  No
Does your baby roll over?  
   Yes  No
Does your child lift his/her head when you lift him/her up out of the car seat?  
   Yes  No

Dental Health:
Does your child’s primary water source contain fluoride?  
   Yes  No  Unsure
   If no, does your child take a fluoride supplement?  
   Yes  No  N/A
Does your child sleep with a bottle?  
   No  Yes
Does your child continuously breastfeed throughout the night?  
   No  Yes

Staying Healthy/Safety:
Does your baby watch TV?  
   No  Yes
Does your home have a working smoke detector?  
   Yes  No
Have you turned your water temperature down to low-warm (less than 120 degrees)?  
   Yes  No  N/A
If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?  
   Yes  No  N/A
Does your home have cleaning supplies/medicines/matches locked away?  
   Yes  No
Does your home have the number of the Poison Control Center (800-222-1222) posted by your phone?  
   Yes  No
Do you always put your baby to sleep on her/his back?  
   Yes  No
Do you always stay with your baby when she/he is in the bathtub?  Yes  No
Do you use sunscreen when your child is outdoors?    Yes  No
Do you always place your baby in a rear-facing car seat in the back seat?   Yes  No
Is your car seat the right one for the age and size of your baby?     Yes  No
Does your baby spend time in a home where a gun is kept?  
   If so, are all guns safely stored in a gun safe or locked  
      with ammunition separate from gun?             Yes  No  N/A
Does your baby spend time with anyone who smokes?          No  Yes

Parental Support:
During the past 2 weeks, how often have you been bothered by the following problems:
   Feeling down, depressed, irritable, or hopeless?
      [Not at all]   [Several days]   [More than half the days]   [Nearly every day]
   Little interest or pleasure in doing things?
      [Not at all]   [Several days]   [More than half the days]   [Nearly every day]

Tuberculosis:
Was your child born in a country with an elevated TB rate?   No  Yes
   This includes all countries other than the United States, Canada, Australia, New Zealand, or countries in western or northern Europe.

Has your child visited or lived in a country with an elevated TB rate for one month or more?  (Countries other than those listed above)  No  Yes

Has your child had contact with someone (including family member, childcare provider, or other caretaker) with known TB infection, or who has been treated for TB infection?  
   No  Yes  Unsure

Is your child immunosuppressed (currently or planned)?  
   This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.  No  Yes

Sleep:
How many hours does your baby sleep at night?  ____ hours
How many hours does your baby nap throughout the day?  ____ hours
Does your baby sleep through the night without feeding?    Yes  No

Nutrition/Physical Activity:
For Breastfeeding:   How many minutes of feeding per side?     ____ minutes
For formula/bottle feeding:  How many ounces per feeding?      ____ oz
If you are giving formula, what brand are you using?  
   ________________
How often does your baby feed?     Every ___ hours
How many feedings of breast milk/formula in 24 hours?     ___ feedings
How much juice does your baby drink in a 24 hour period?     ___ oz
Have you started feeding your baby a variety of solid foods?     Yes  No
Do you give your baby a bottle of anything other than formula,   
breast milk or water?     No  Yes
Do you have any concerns about your baby’s feeding?     No  Yes

**Elimination:**
Does your baby have bowel movements on a regular basis with a normal,   
soft consistency?     Yes  No

Please list any medications or supplements your baby is taking, including vitamin D:
______________________________________________________________________________________________
Who lives in the home with your baby? ___________________________________________________________
Who provides daytime care for your baby? _________________________________________________________
Please list any major family medical issues:_________________________________________________________
Please list any known allergies to medicine:_________________________________________________________
Please list any known food allergies:______________________________________________________________
Do you have any concerns about your child’s development, or any other concern you would like to discuss with your   
provider?________________________________________________________________________________________________

**Parent or Guardian Signature:** _________________________________________________________________

Date: ___________________________________________________________________

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PCP’s Signature ______________________ Print Name: ______________________ Date: ______________________

[ ] Patient Declined the SHA