Patient Name

Date of Birth

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? No ☐ Yes ☐ Skip ☐

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)? No ☐ Yes ☐
This includes HIV infection, organ transplant recipient, other immune system problems, or treatment with immunosuppressive medications.

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: _____

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	☐ **Patient Declined the SHA**
PCP's Signature		Print Name:			Date:

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