



## 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: \_\_\_\_\_

<b><i>Clinic Use Only</i></b>	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b><input type="checkbox"/> Patient Declined the SHA</b>
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name:		Date:	