Stanford Children's Health

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	

Tuberculosis Screening:

Has a family member or contact had tuberculosis or a positive tuberculin skin test (PPD)?	No	Yes	Unsure
Was your child born in a high risk country (countries ***other than*** the US, Canada, Australia, New Zealand or Western Europe?	No	Yes	
Has your child traveled to (***or*** had contact with people who live in a high risk country) for more than one week? (Countries ***other than*** the US, Canada, Australia, New Zealand or Western Europe)	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

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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 <u>medicine</u>: ______________________________________

Please list any known <u>food</u> allergies: ______________________________________

Do you have any concerns about your child's development, or any other concern you would like to discuss with your provider?

____

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:

Ver.5-7-15