6 month – well child care **Patient Name:______________________D.O.B_______**

Please fill in the blank or check the appropriate answer as it pertains to your child.

Household
Who lives in the home (e.g. Father, mother, brother, sister, etc.)? ___________________________________

Does your child attend daycare?_______________________ ▢ Yes ▢No

Development
Takes turns making sounds with you____________________ ▢ Yes ▢No
Blows "raspberries" (sticks tongue out and blows)_________ ▢ Yes ▢No
Makes squealing noises_____________________________ ▢ Yes ▢No
Puts things in their mouths to explore them______________ ▢ Yes ▢No
Rolls from tummy to back___________________________ ▢ Yes ▢No
Pushes up with arms straight when on tummy____________ ▢ Yes ▢No
Leans on hands to support himself when sitting__________ ▢ Yes ▢No
Reaches out to grab a toy they want___________________ ▢ Yes ▢No
Closes lips to show they do not want more food__________ ▢ Yes ▢No
Knows familiar people______________________________ ▢ Yes ▢No
Likes to look at themselves in the mirror_______________ ▢ Yes ▢No
Laughs_______________________________________ ▢ Yes ▢No

Nutrition
What types of baby food are being given?____________________________ ▢Breast Fed ▢Formula

How much and how frequent?____

If breastfeeding, is the baby receiving a vitamin D supplement? ▢ Yes ▢No

Wakes for feeds overnight?__________________________ ▢ Yes ▢No

Bowel habits
How many stools does you child have per day? ____

What do the stools look like (soft, seedy, loose)? ____

Sleep Pattern

Sleeps on back?___________________________________ ▢ Yes ▢No

Sleeps through the night in their own crib?______________ ▢ Yes ▢No

Safety
Is your child's car seat rear facing and in the back seat?_______ ▢ Yes ▢No
Is your child exposed to tobacco smoke?________________ ▢ Yes ▢No
Are there any improperly stored firearms in the home?_______ ▢ Yes ▢No
Is the hot water temperature set low enough
to prevent accidental burns?____________________ ▢ Yes ▢No
Are there working smoke detectors in the home?___________ ▢ Yes ▢No

Please share any concerns that you have about your child here:_______________________________

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Please complete both sides of this form

Please circle any of the questions below to which your answer is "YES".

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, or eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead?
- Uses products from other countries such as health remedies, spices, or food, or stores or serves food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Your child was born in, traveled to or lived in a "tuberculosis high-risk" country?
- Your child has a family member or has had contact with anyone with either active tuberculosis or a history of tuberculosis disease?
- Your child has a family member with a positive tuberculin skin test?

Social Determinants of Health Assessment:

- Within the past 12 months, have you had worries that food would run out before your family got enough money to buy more?
- Within the past 12 months, were there times that food ran out and your family didn't have enough money to get more?
- Have you needed help reading instructions, pamphlets, or other written material from a doctor or pharmacy?
- In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
- In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Below this line is for Office Use:

Weight ____

Height ____

Head Circumference ____________________________________

Please complete both sides of this form