UW Medicine
UW NEIGHBORHOOD CLINICS

6 Month Old Well Child Visit

Baby's Name_____ Age _____Date:_____

Person completing the form:_____Relationship to the patient:_____

Has your child had any illnesses, hospitalizations or surgeries since last visit? (YES) (NO)

Review ofNutrition:	Yes	No	
Is your baby feeding well?	( )	( )	
Is your baby breast fed? Is yes, how often?	( )	( )	
Is your baby formula fed? If yes what formula?	( )	( )	
How many ounces per feeding? and how often?	( )	( )	
Have you introduced baby food?	( )	( )	

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	( )	( )
Are there any major stressors in the family (illness, moves, death, separation)?	( )	( )

Preventative Health/Risk Factors:

Does your baby sleep on his/her back in his/her own crib?	( )	( )
Is your child exposed to TV or videos?	( )	( )
Does your child always ride in a car seat that is rear facing?	( )	( )
Do you, or anyone who cares for your child or anyone in the home smoke?	( )	( )
Do you feel your home is childproofed?	( )	( )
Do you have the poison control # (800-222-1222)?		

Behavioral/Mental Health:

Does your child have a regular sleep routine?	( )	( )
Do you have any concerns about your child's learning, development or behavior?	( )	( )
Are you interested in enrolling your child in daycare?	( )	( )
Do you need assistance enrolling your child in daycare?	( )	( )

Developmental Surveillance:	Yes	No
Physical Development:		
Sits briefly leaning forward?	( )	( )
Rolls over?	( )	( )
Cognitive:		
Likes to look around?	( )	( )
Puts things in mouth?	( )	( )
Communicative:		
Babbles?	( )	( )
Beginning to recognize own name?	( )	( )
Tries to "talk" to you?	( )	( )
Social/Emotional:		
Likes to play with you?	( )	( )