UW Medicine
UW NEIGHBORHOOD CLINICS

Six Month Old Well Child Visit

Baby's Name ______________________________________ Baby's Birth Date ______________________

Please fill out the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Review of Nutrition	Yes	No
Is your baby starting any solid foods?	( )	( )
Is your baby feeding well?	( )	( )
Is your baby stooling comfortably?	( )	( )
If breastfed, is your baby getting a daily vitamin?	( )	( )

Social Screening	Yes	No
What are your current child-care arrangements?		
Is your mood good overall?	( )	( )
Is your home smoke-free? (choose "No" even if smoking is outside)	( )	( )
Is your home free of risky toys, such as infant walkers and small toys that are choking hazards?	( )	( )
Do you have the Poison Control # (800-222-1222) programmed into your phone and/or posted on your refrigerator?	( )	( )
Are cabinet locks, outlet plugs, stair-gates, and window guards installed where necessary?	( )	( )
Does your baby still ride in a rear-facing car seat in the back seat?	( )	( )

Sleep	Yes	No
Is your baby able to fall asleep when put down while still awake?	( )	( )
Can your baby sleep through the night?	( )	( )
Do you keep nighttime visits brief and boring?	( )	( )
Does your baby sleep on her/his back/side?	( )	( )
Does your baby sleep in her/his own crib?	( )	( )

Developmental Screening	Yes	No
Does your baby sit briefly, leaning forward?	( )	( )
Does your baby hold her/his head upright and steady?	( )	( )
Does your baby babble?	( )	( )
Does your baby transfer objects from hand to hand?	( )	( )
Does your baby pick up toys if placed within reach?	( )	( )
Does your baby use both hands equally?	( )	( )
Do you think your baby sees and hears well?	( )	( )

Has your baby had any significant illnesses since the last time we saw you? If yes, please describe:

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Are there any new stresses on your family since the last time we saw you? If yes, please describe:

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Current concerns not listed above:

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