

6-Month-Old Well Child Visit

Baby's Name: _____ Baby's Age: _____ Date: _____

Person completing the form _____ Relationship to the patient _____

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

Nutrition:	Yes	No
Is your baby feeding well?	<input type="checkbox"/>	<input type="checkbox"/>
Is your baby breastfed?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, how often? _____		
Is your baby formula fed? If yes:	<input type="checkbox"/>	<input type="checkbox"/>
• What formula? _____		
• How many ounces per feeding? _____		
• How often? _____		
Are you giving your baby vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
Have you introduced baby food?	<input type="checkbox"/>	<input type="checkbox"/>

Family and Social History:	Yes	No
Are there any major illnesses in the family that we are not already aware of?	<input type="checkbox"/>	<input type="checkbox"/>
Are there any major stressors in the family (illness, moves, death, separation)?	<input type="checkbox"/>	<input type="checkbox"/>

Preventative Health/Risk Factors:	Yes	No
Does your child sleep on his/her back?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep in his/her own bassinet or crib?	<input type="checkbox"/>	<input type="checkbox"/>
How many hours of TV or video is your child exposed to per day? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child always ride in a car seat, in the back seat, facing backwards?	<input type="checkbox"/>	<input type="checkbox"/>
Do you, anyone in your home, or anyone who cares for your child smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel your home is childproofed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have the poison control phone number? (800-222-1222)	<input type="checkbox"/>	<input type="checkbox"/>

Behavioral/Mental Health:	Yes	No
Does your child have a regular sleep routine?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any concerns about how your child is learning, developing and behaving?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in enrolling your child in daycare?	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, do you need assistance to find a suitable program?	<input type="checkbox"/>	<input type="checkbox"/>

Developmental Surveillance:

Physical Development:	Yes	No
Sits briefly leaning forward?	<input type="checkbox"/>	<input type="checkbox"/>
Rolls over?	<input type="checkbox"/>	<input type="checkbox"/>

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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Cognitive Development:	Yes	No
Likes to look around?	<input type="checkbox"/>	<input type="checkbox"/>
Puts things in mouth?	<input type="checkbox"/>	<input type="checkbox"/>

Social/Emotional Development:	Yes	No
Likes to play with you?	<input type="checkbox"/>	<input type="checkbox"/>

Communicative Development:	Yes	No
Babbles?	<input type="checkbox"/>	<input type="checkbox"/>
Beginning to recognize own name?	<input type="checkbox"/>	<input type="checkbox"/>
Tries to "talk" to you?	<input type="checkbox"/>	<input type="checkbox"/>

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