Well Child Care 6 months

Name : DOB: Date:

Do you have any concerns today ? □ No Yes_____

Nutrition/Review of systems	yes	no	Review of systems/symptoms	yes	no
Breast feeding ?			Any Vision Problems?		
Bottle feeding ?			Any hearing problems?		
Eating solids ?			Any breathing problems ?		
Spits up ? if yes, is spitting up forceful ?			Any skin problems?		
Drinks milk? _____oz/day			Any heart problems ?		
Drinks juice ? _____oz/day			Any sleep concerns?		
Bowel movements normal ?			Any past bad reactions from immunizations ?		
Has hard stool /cries with bowel movements ?			Any lead poisoning risks?		
Immunizations up to date?			Any TB Exposure?		
Social/Family History:					
Parents working outside home □ *Mom* □ *Dad*			Maternal depression ?		
Child care ?			Changes since last visit ?		
Oral Health risk Assessment:					
Mother or primary care giver had active tooth decay in past 12 mo?			Mother or primary caregiver has a dentist ?		
Special care needs child?			Medicaid eligible ?		
Child has teeth ?			Water supply □ city □ well □ drink bottled water		
Developmental Questions: Does your baby					
Make happy, high pitched squealing sounds?			Sit without support?		
Make consonant sounds, 'da', 'ga', 'ba'?			Roll over?		
Imitate speech sounds?			Lift chest using arms for support?		
Pass things from hand to hand?			Work to get a toy out of reach?		
Feeding self?			Do you have any concerns about your baby's development?		
Safety issues:					
Family violence & substance abuse? circle			Using rear facing car seat?		
Exposed to passive smoking?			Fall, Fire and Burn precaution in place ?		
Home swimming pool ?			Medication, personal hygiene products, alcohol, cleaning supplies ,trash containers out of reach?		
Family history:					
High cholesterol ,Triglycerides			Obesity		
Diabetes			Early Heart disease ,Hypertension		

Anticipatory guidance: □ *discussed and /or handout given*

Family Functioning : □ *domestic violence* □*time for self/partner*

Infant Development: □ *social development* □*Communication skills* □ *sleep* □*No TV*

Nutrition & Feeding: □ *breast feeding (Vitamin D, Iron supplement)* □*iron-fortified formula* □ *solid foods : types & amounts* □*begin cup* □*Elimination*

Oral Health : □ *Avoid bottle in bed* □ *Brush teeth*

Safety: □ *car safety seat* □ *poisons* □ *Burns (hot water)* □ *Falls* □ *Infant walkers* □*Drowning* □*Choking (finger foods)* □*kitchen safety*

Immunization: □ *Risks, benefits, side effects, alternative* □ *refused, vaccine refusal form signed*.

Signature of parent/guardian: **Provider Signature:**