6 Month Visit

This section to be completed by the parent…

Patient name Date

Are you concerned about your baby's……..

1. Feedings ?	Breast?	Formula?	Both?	**YES**	**NO**
2. Excessive spitting or vomiting?				**YES**	**NO**
3. Bowel movements or urination?				**YES**	**NO**
4. Congestion or wheezing?				**YES**	**NO**
5. Skin color or rashes?				**YES**	**NO**
6. Excessive crying?				**YES**	**NO**
7. Sleep patterns?				**YES**	**NO**
8. Development?				**YES**	**NO**

Does your child…..

1. Sleep on his/her back?	**YES**	**NO**
2. Fall asleep without help? (self soothe to sleep?)	**YES**	**NO**
3. Transfer objects hand to hand?	**YES**	**NO**
4. Squeal, babble, crow or imitate sounds?	**YES**	**NO**
5. Seem to hear well?	**YES**	**NO**
6. Move all extremities equally well?	**YES**	**NO**
7. Roll over?	**YES**	**NO**
8. Bat at objects?	**YES**	**NO**
9.Reach and grab objects?	**YES**	**NO**
10. Ride in a rear facing car-seat?	**YES**	**NO**
11. Sleep in his/her own crib?	**YES**	**NO**

Does your house…..

1. Have community water? (Not well water)	**YES**	**NO**
2. hot water heater turned down to 120-130 defrees F?	**YES**	**NO**
3. Gates at the top of steps?	**YES**	**NO**
4. Poisons and household chemicals stored out of reach?	**YES**	**NO**
5.Small objects that may cause choking out of your baby's reach?	**YES**	**NO**

Do you have any other concerns you wish to discuss?

For Office Use Only

WT HT HC PO