



PATIENT NAME _____ BIRTH DATE ____/____/____ AGE TODAY _____

PARENTS _____ TODAY'S DATE ____/____/____

PARENTS' CONCERNS

Parents, what concerns do you have about your child? →

Please circle any body areas that concern you:

Head	Heart	Bones	Hormones
Eyes	Lungs	Joints	Blood
Ears	Intestines	Muscles	Glands
Nose	Kidneys	Brain	Immunity
Mouth	Genitals	Nerves	
Throat	Skin	Mental Health	

Answer the questions below and / or check YES or NO.

PATIENT INFORMATION	PHYSICIAN'S COMMENTS
<p>HISTORY</p> <p>Describe had any recent injuries or illnesses: _____</p> <p>List medications taken routinely: <input type="checkbox"/> none</p> <p>Note any new stresses in the family: _____</p> <p>Is your baby in day care? <input type="checkbox"/> No <input type="checkbox"/> Home based <input type="checkbox"/> Center based <input type="checkbox"/> Nanny <input type="checkbox"/> Other: How many kids? _____</p> <p>Are there smokers in your baby's home or daycare? <input checked="" type="checkbox"/> No <input type="checkbox"/> outside <input type="checkbox"/> other room</p> <p>Does your child drink water that is fluoridated? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>NUTRITION</p> <p>Y N Have you given any baby foods? <input type="checkbox"/> cereal <input type="checkbox"/> fruits <input type="checkbox"/> veggies <input type="checkbox"/> meat <input type="checkbox"/> juice</p> <p>FORMULA FEEDING: How many ounces in 24 hrs? _____ What formula? _____</p> <p>BREAST FEEDING: How many times does baby nurse in 24 hours? How many minutes is each feeding? Y N <input checked="" type="checkbox"/> Is baby fed on demand? <input type="checkbox"/> Have you given supplemental formula? <input checked="" type="checkbox"/> Are you pumping breast milk?</p> <p>Y N <input checked="" type="checkbox"/> Does baby spit up? If yes, how many times per day? _____ <input checked="" type="checkbox"/> Are there any problems passing stool?</p>	<p>☞ Pincer grasp is cue to self feeding and safety issues.</p> <p><input type="checkbox"/> Discussed risks of 2nd hand smoke.</p> <p><input type="checkbox"/> Prescribed fluoride vitamins.</p> <p>Shaded items are new for the 6 mo check-up.</p> <p>GENERAL FEEDING RECOMMENDATIONS</p> <p><input type="checkbox"/> Formula with iron until age 1. <input type="checkbox"/> Iron fortified rice cereal, 2 tbsp/day. <input type="checkbox"/> May eat from #2 baby food jars. <input type="checkbox"/> Puree your own food if desired. <input type="checkbox"/> Gradually introduce finger foods. <input type="checkbox"/> Introduce a cup. <input type="checkbox"/> Never allow a bottle in bed (causes cavities). <input type="checkbox"/> Fluoride and Vitamins only if prescribed.</p> <p>BREAST FEEDING RECOMMENDATIONS</p> <p><input type="checkbox"/> Might be sleeping through the night. <input type="checkbox"/> May follow lower percentile on weight growth curve. <input type="checkbox"/> Nurse until at least 1 year old, if possible. <input type="checkbox"/> 6-12 feedings in 24 hrs is typical. <input type="checkbox"/> Baby is easily distracted, not disinterested. <input type="checkbox"/> Nurse in a quiet place. <input type="checkbox"/> Expect growth spurt at 6 months. <input type="checkbox"/> Back to work? Pump and freeze milk properly. <input type="checkbox"/> Mom should not diet. Drink to thirst.</p> <p>STOOLING EXPECTATIONS</p> <p><input type="checkbox"/> Stools will change when food is given. <input type="checkbox"/> Stool frequency is variable, but should not be hard balls.</p>

PHYSICAL EXAM	LAB	IMMUNIZATIONS																				
<p>Ht _____ Wt _____ HC _____ VS: _____</p> <p>Check if normal:</p> <table style="width:100%"> <tr> <td><input type="checkbox"/> Head/Fontanel</td> <td><input type="checkbox"/> Nose</td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/> Back</td> </tr> <tr> <td><input type="checkbox"/> Eyes/Red reflexes</td> <td><input type="checkbox"/> Mouth</td> <td><input type="checkbox"/> Heart</td> <td><input type="checkbox"/> Hips</td> </tr> <tr> <td><input type="checkbox"/> Ears</td> <td><input type="checkbox"/> Throat</td> <td><input type="checkbox"/> Femoral pulses</td> <td><input type="checkbox"/> Extremities</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Abdomen</td> <td><input type="checkbox"/> Skin</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Genitalia</td> <td><input type="checkbox"/> Neurologic</td> </tr> </table> <p>NOTE EXAM ABNORMALITIES HERE</p>	<input type="checkbox"/> Head/Fontanel	<input type="checkbox"/> Nose	<input type="checkbox"/> Lungs	<input type="checkbox"/> Back	<input type="checkbox"/> Eyes/Red reflexes	<input type="checkbox"/> Mouth	<input type="checkbox"/> Heart	<input type="checkbox"/> Hips	<input type="checkbox"/> Ears	<input type="checkbox"/> Throat	<input type="checkbox"/> Femoral pulses	<input type="checkbox"/> Extremities		<input type="checkbox"/> Neck	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Skin		<input type="checkbox"/> Chest	<input type="checkbox"/> Genitalia	<input type="checkbox"/> Neurologic		<p><input checked="" type="checkbox"/> Given at Health Department</p> <p>Shots up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No Any previous side effects? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____</p> <p><input type="checkbox"/> DTaP <input type="checkbox"/> HepB <input type="checkbox"/> IPV <input type="checkbox"/> Hib <input type="checkbox"/> Comvax <input type="checkbox"/> Other: <input type="checkbox"/> Prevnar</p>
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ASSESSMENT

- NORMAL GROWTH and DEVELOPMENT. More information on other side.
- _____
- _____
- _____
- _____

PLAN

- Follow up at **9 months** for Health Review. Anticipatory handouts given.
- _____
- _____
- _____
- _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

DEVELOPMENT AND BEHAVIOR	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you concerned about your child's development or behavior?	
Y N <input type="checkbox"/> <input type="checkbox"/> Does baby turn his/her head toward your voice? <input type="checkbox"/> <input type="checkbox"/> Does baby follow your face or an object with his/her eyes through 180 degrees?	
M O T O R	Y N <input type="checkbox"/> <input type="checkbox"/> Does baby hold his/her head straight when pulled from a lying to sitting position? <input type="checkbox"/> <input type="checkbox"/> Does s/he sit with support or lean forward on the hands? <input type="checkbox"/> Sits alone <input type="checkbox"/> <input type="checkbox"/> Does s/he roll over? <input type="checkbox"/> <input type="checkbox"/> Does baby bear weight on the legs if held upright? <input type="checkbox"/> <input type="checkbox"/> Does baby play with his/her feet? <input type="checkbox"/> <input type="checkbox"/> Will s/he reach for a toy and transfer it from one hand to the other? <input type="checkbox"/> <input type="checkbox"/> Does baby "rake" objects up with sides of hands and thumb?
L A N G U A G E	Y N <input type="checkbox"/> <input type="checkbox"/> Do you talk, read and sing to baby?
S O C I A L	Y N <input type="checkbox"/> <input type="checkbox"/> Does s/he get upset if a toy is taken away? <input type="checkbox"/> <input type="checkbox"/> Does s/he initiate social contact by babbling, smiling, cooing, laughing and squealing? <input type="checkbox"/> <input type="checkbox"/> Is baby starting to experience "stranger anxiety?" <input type="checkbox"/> <input type="checkbox"/> Does s/he enjoy peek-a-boo, so-big and pat-a-cake games? <input type="checkbox"/> <input type="checkbox"/> Does s/he seem to be "teething?" (Teeth usually appear after 6 months. Timing of later teeth varies greatly.)
S L E E P	How many hours does baby sleep at a stretch overnight? _____ Y N <input type="checkbox"/> <input type="checkbox"/> Are you satisfied with baby's sleep habits? (Separation anxiety may cause sleep problems.) <input type="checkbox"/> <input type="checkbox"/> Have you established a bedtime routine? <input type="checkbox"/> <input type="checkbox"/> Do you put baby down when drowsy to teach self-quieting? <input type="checkbox"/> <input type="checkbox"/> Are you OK with baby's self comforting behaviors? <input type="checkbox"/> pacifier <input type="checkbox"/> thumb sucking <input type="checkbox"/> neither <input type="checkbox"/> <input type="checkbox"/> Do you avoid giving him/her a bottle in the crib? (This could cause cavities.) <input type="checkbox"/> <input type="checkbox"/> Do you avoid bulky bedding in the crib? Where does baby usually sleep?

SAFETY AWARENESS					
Please review the shaded items, which are new for the 6 month visit. If you reviewed the remaining items previously, check this box. <input type="checkbox"/>					
Y N	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%; padding: 5px;"> <input type="checkbox"/> <input type="checkbox"/> Is baby's car seat rear facing in the back seat? → <input type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of baby's reach? <input type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy? <input type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach? <input type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers? <input type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair? <input type="checkbox"/> <input type="checkbox"/> Do you always closely monitor baby while s/he is in the bath tub? <input type="checkbox"/> <input type="checkbox"/> Do you have gates to guard open stairways? <input type="checkbox"/> <input type="checkbox"/> Are sharp table edges protected? <input type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your baby? <input type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on? </td> <td style="width: 20%; border: 1px dashed black; padding: 5px; vertical-align: top;"> If baby is outgrowing the infant carrier car seat (usually at around 20 lbs) switch to a "convertible" car seat. It must remain rear facing until both 1 yr old AND 20 lbs. </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> <input type="checkbox"/> Do you avoid drinking hot liquids while holding your baby? <input type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure? <input type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> <input type="checkbox"/> Do you avoid putting baby in the car seat / bouncy seat set in high places? <input type="checkbox"/> <input type="checkbox"/> Do you avoid the use of baby walkers? <input type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage and small parts that may cause choking? <input type="checkbox"/> <input type="checkbox"/> Are you aware that shaking your baby could cause permanent brain damage? </td> <td></td> </tr> </table>	<input type="checkbox"/> <input type="checkbox"/> Is baby's car seat rear facing in the back seat? → <input type="checkbox"/> <input type="checkbox"/> Are medications, poisons and plants out of baby's reach? <input type="checkbox"/> <input type="checkbox"/> Do you have the Poison Control Center's number handy? <input type="checkbox"/> <input type="checkbox"/> Do you keep your curling iron out of reach? <input type="checkbox"/> <input type="checkbox"/> Have you inserted electrical outlet covers? <input type="checkbox"/> <input type="checkbox"/> Do you watch for frayed electrical cords in need of repair? <input type="checkbox"/> <input type="checkbox"/> Do you always closely monitor baby while s/he is in the bath tub? <input type="checkbox"/> <input type="checkbox"/> Do you have gates to guard open stairways? <input type="checkbox"/> <input type="checkbox"/> Are sharp table edges protected? <input type="checkbox"/> <input type="checkbox"/> Do you keep balloons and plastic wrappers away from your baby? <input type="checkbox"/> <input type="checkbox"/> Do you keep small items out of reach which baby could choke on?	If baby is outgrowing the infant carrier car seat (usually at around 20 lbs) switch to a "convertible" car seat. It must remain rear facing until both 1 yr old AND 20 lbs.	<input type="checkbox"/> <input type="checkbox"/> Is the water temperature in your house less than 120 degrees? <input type="checkbox"/> <input type="checkbox"/> Do you avoid drinking hot liquids while holding your baby? <input type="checkbox"/> <input type="checkbox"/> Do you limit sun exposure? <input type="checkbox"/> <input type="checkbox"/> Do you have a fire escape plan? <input type="checkbox"/> <input type="checkbox"/> Do you check your smoke detectors regularly? <input type="checkbox"/> <input type="checkbox"/> Do you avoid putting baby in the car seat / bouncy seat set in high places? <input type="checkbox"/> <input type="checkbox"/> Do you avoid the use of baby walkers? <input type="checkbox"/> <input type="checkbox"/> Do you check toys for breakage and small parts that may cause choking? <input type="checkbox"/> <input type="checkbox"/> Are you aware that shaking your baby could cause permanent brain damage?	
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Who answered the above questions? _____ Thank you for helping us help you and your child!!
Please put this paper in the box hanging outside the door so that we know you are finished!