CHILDREN FIRST
DUMFRIES PEDIATRICS

Well Child Check: 6 Month Visit

Your Child's Name: _____

Please answer the following questions. It will help your clinicians spend more time discussing those specific issues that concern you. PLEASE FILL OUT BOTH SIDES.

Does your child roll over?	Yes	No	Unsure
Does your child lift the head up as you get him/her out of the car seat?	Yes	No	Unsure
Does your child sit with your help?	Yes	No	Unsure
Does your child reach and grab for things?	Yes	No	Unsure
Does your child reach using a raking grasp (this means using the entire hand with outstretched fingers to grab at objects)?	Yes	No	Unsure
Does your child turn toward sound?	Yes	No	Unsure
Does your child babble (make sounds such as "ba", "ma", "ga")?	Yes	No	Unsure
Does your child smile at you?	Yes	No	Unsure
Does your baby drink breast milk or formula?	Breast milk	Formula	Both

If you are giving formula how many ounces does your child take in 24 hours?_____ oz.

Type of formula?

Are you satisfied with your child's sleep?	Yes	No	Unsure
Does your child sleep through the night?	Yes	No	Unsure
Is your home child-proofed?	Yes	No	Unsure
Do you usually protect your child with sunscreen/hats/other measures when outdoors?	Yes	No	Unsure
Do you have the poison control number (800 222-1222) posted at home?	Yes	No	Unsure
Does your child have access to a pool that does not have a locked gate?	No	Yes	Unsure
Does your child use a walker (one that moves on wheels?)	No	Yes	Unsure
Do you have any other safety concerns at your home?	No	Yes	Unsure

If so, what are your concerns?

Has mom been feeling sad, anxious, hopeless or depressed often?	No	Yes	Unsure

Who provides daytime care for your child? _____

Does your water contain fluoride?	Yes	No	Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:

Do you have any international travel plans prior to your child's first birthday? If so, when and where?

CONTINUES ON OTHER SIDE

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Risk Assessment for Lead Exposure:

Does your child frequently put paint chips, or dirt in his/her mouth or chew on window sills or blinds?	Yes	No	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 with peeling or chipping paint inside or outside the home?	Yes	No	Unsure
Does your child have a sibling or playmate who has or did have lead poisoning?	Yes	No	Unsure
Does your family use any of the following IMPORTED items: pottery for cooking or storing food, home remedies, dietary/herbal supplements, candy or eyeliner, (Kohl, Greta, Azarcon,Pay-loo-ah or others)?	Yes	No	Unsure

IF YES, please specify: _____

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease?	Yes	No	Unsure
Since your child's last well check has a family member or contact had a positive tuberculosis test?	Yes	No	Unsure
Was your child born in a high-risk country (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	Yes	No	Unsure
Has your child traveled to (or had contact with people who live in) a high-risk country for more than one week (Countries other than the United States, Canada, Australia, New Zealand, or western European countries)?	Yes	No	Unsure

Do you have any concerns about your child's development, or any other concerns you would like to discuss with your provider?

If so, please describe:

_____

_____

_____

CONTINUES ON OTHER SIDE