6 Month Old Questions **Name, Date of birth _____**

Who is the baby here with today? _____

GENERAL:

Illnesses, injuries, surgeries, hospitalizations since last visit? _____

Medications: _____

Medication allergies: _____

Immunization reactions: _____

Maternal medications: _____

Is your child taking vitamins? (Circle what applies) Fluoride, Multi-vitamin, None

SOCIAL:

Changes in child's environment? _____

Who lives with the child in your home? #____Mom, #____ Dad , #____ Brother, # ____ Sister, _____other

Water source: CITY, WELL, BOTTLED

Tobacco exposure: YES, NO

Pets?_____

Daycare: YES, NO

FEEDING:

BREASTFEEDING? YES, NO _____

FORMULA FEEDING? YES, NO _____

Problems spitting up? YES, NO

ELIMINATION: Any issues urinating or with bowel movements? _____

SLEEP: How many hours without waking through the night?_____

BEHAVIOR (circle what applies) No problems or not crying excessively, Occasionally fussy, Frequently fussy

DEVELOPMENT:

1- Holds head steady: YES, NO

2- Transfers from hand to hand: YES, NO

3- Sits supported/alone: YES, NO

4- Rolls front to back: YES, NO

5- Rolls back to front: YES, NO

6- Bears weight on lower extremities: YES, NO

7- Explores with hand/mouth: YES, NO

8- Turns to sound: YES, NO

9- Babbles: YES, NO

10- Laughs: YES, NO

11- Blows raspberries: YES, NO

12- Shows likes and dislikes: YES, NO

13- Enjoys social play: YES, NO

14- Do you think that your child hears well? YES, NO

15- Do you think that your child sees well? YES, NO

16- Do you read to your child? YES, NO

Lead Questions:

Does your child live in or often visit a house that had been built before 1978? YES, NO

Does your child live in or often visit a house that is being remodeled or is having paint removed? YES, NO

Does your child live with or often visit another child who has an elevated lead level? YES, NO

Does your child have a hobby that uses lead? YES, NO

Does your child chew on or non-food items like paint chips or dirt? YES, NO

Does the child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? YES, NO

TB Questions

Does your child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or abnormal chest x-ray?

YES, NO, UNKNOWN

Has your child been in close contact with a person sick with active TB? YES, NO, UNKNOWN

Has your child been exposed to anyone who has been in jail or prison in the past 5 years? YES, NO, UNKNOWN

Was your child born outside of the U.S. or has your child traveled outside the U.S.? YES, NO, UNKNOWN

Does your child have a household member who was born outside the U.S. or who has traveled outside the U.S.? YES, NO, UNKNOWN

Has your child been exposed to any of the following?

HIV infected individuals? YES, NO, UNKNOWN

Homeless persons YES, NO, UNKNOWN

Users of IV and/or other street drugs? YES, NO, UNKNOWN

Residents of nursing homes or group home? YES, NO, UNKNOWN

Migrant workers? YES, NO, UNKNOWN

Does your child have HIV, or risk factors for HIV or any other health problem that could lower the immune system? YES, NO, UNKNOWN

Has your child ever been in jail? YES, NO, UNKNOWN

{International Travel: Exposure to anyone who has traveled outside the United States in last 60 days: YES, NO