6 Month Well Child Check Name_____

Allergies_____Current Meds_____

Is your baby healthy?	**Yes**	**No**_____
Do you feel your baby is developing normally?	Yes	No_____
Do you think your baby can hear?	Yes	No_____
Do you think your baby can see?	Yes	No_____
Do your baby's eyes turn inward or outward or cross?	No	Yes_____
Does your baby have normal stools?	Yes	No_____
Does your baby have 4-6 wet diapers/day?	Yes	No_____
Does your baby sleep at least a 4-6 hour stretch at night?	Yes	No_____
If breastfeeding—are you having any problems?	**No**	**Yes**_____
How often is your baby nursing?		_____
If formula feeding—Type of formula?		_____
How many ounces/how often?		_____
Has your baby started solids?	Yes	No
Does your baby take a vitamin or supplement?	Yes	No
Is there Fluoride in your drinking water? (city water=yes)	**Yes**	**No**
Is your baby in childcare?	No	Yes_____
Has there been any recent change to your family structure?	No	Yes_____
Does anyone in your household smoke ?	No	Yes
Do you have childcare plans?	No	Yes_____
Does your baby take naps?	**Yes**	**No**_____

Do you have any other concerns?_____

_____

Development (Do not complete if given Ages and Stages Questionnaire)

Does your baby vocalize single consonants?	Yes	No
Does your baby smile, laugh or imitate?	Yes	No
Does your baby turn towards noises?	Yes	No
Does your baby sit with support?	Yes	No
Does your baby use his/her hand in a raking motion to move or grasp small objects?	Yes	No
Does your baby put objects in his/her mouth?	Yes	No
Does your baby transfer an object from hand to hand?	Yes	No
Is your baby starting to feed him/herself?	Yes	No

Updated 01/25/13