OPTUM®

Department of Pediatrics
1-719-522-1134 TTY **711**

# Well-check questionnaire

## 6 month well-check

**Patient name:** ________________ **DOB:** ________________ **Today's date:** ________________

**Medications:** ________________ **Allergies:** ________________

**Mother's maiden name:** ________________

Are you breast or formula feeding? ________________

Name of formula: ________________ Ounces per feeding: ________________

# Of wet diapers a day: ________________ # Of stools a day: ________________

| Question | | |
|---|---|---|
| Do you have any concerns with feedings? | ☐ No | ☐ Yes |
| Does your baby eat baby food or cereal? | ☐ No | ☐ Yes |
| Is your baby drinking anything other than breastmilk or formula? | ☐ No | ☐ Yes |
| Do you have concerns with your baby's bowel movements? | ☐ No | ☐ Yes |
| Is your baby sleeping through the night? | ☐ No | ☐ Yes |
| Does your baby sleep in a crib or bassinet? | ☐ No | ☐ Yes |
| Does your baby go to a daycare home or center? | ☐ No | ☐ Yes |
| Is your baby always in a car seat when riding in a vehicle? | ☐ No | ☐ Yes |
| Is your hot water heater turned down to 120? | ☐ No | ☐ Yes |
| Does your home have smoke and carbon monoxide detectors? | ☐ No | ☐ Yes |
| Is your baby exposed to secondhand smoke at home, in cars or at daycare? | ☐ No | ☐ Yes |
| Do you have outlet protectors and safety gates? | ☐ No | ☐ Yes |
| Do you know what to do if your baby chokes? | ☐ No | ☐ Yes |

**Does your baby:**

| Question | | |
|---|---|---|
| Sit briefly? | ☐ No | ☐ Yes |
| Turn head to sound? | ☐ No | ☐ Yes |
| Roll back-to-front and vice versa? | ☐ No | ☐ Yes |
| Bear weight on legs when held? | ☐ No | ☐ Yes |
| Transfer objects from hand to hand? | ☐ No | ☐ Yes |
| Vocalize with squeals, growls or other coos? | ☐ No | ☐ Yes |
| Blow "raspberries/bubbles" with lips? | ☐ No | ☐ Yes |
| Have any eye crossing? | ☐ No | ☐ Yes |

**Is your baby:**

| Question | | |
|---|---|---|
| Quick to agitation? | ☐ No | ☐ Yes |
| Difficult to soothe? | ☐ No | ☐ Yes |
| Irritable with feedings? | ☐ No | ☐ Yes |

Any questions or concerns: ________________

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