

# 6 MONTH HEALTH QUESTIONNAIRE



**This information is confidential.**

Your answers help your physician or nurse practitioner choose the best topics to discuss with you at this visit. Skip any questions you don't understand or do not apply.

PHONE: \_\_\_\_\_

## HOW DOES YOUR BABY SPEND HIS/HER DAY? DO YOU HAVE ANY QUESTIONS OR CONCERNS?

1. Do you feed your baby breastmilk?  No  Yes
2. Do you feed your baby infant formula with iron?  No  Yes
3. Does your baby eat infant cereal, baby, or strained foods, two to three meals a day?  No  Yes
4. Do you offer new foods every five to seven days?  No  Yes
5. What city do you live in? \_\_\_\_\_
6. Do you keep all medications, house cleaning products, and poisons in a locked cabinet out of sight?  No  Yes
7. Do you have the poison control center phone number near your telephone?  No  Yes
8. Do you have syrup of ipecac in your home?  No  Yes
9. Does your baby spend time in a home where anyone smokes?  Yes  No
10. Since your last well check, have there been any MAJOR illnesses, hospitalizations, surgeries, changes, or stresses for your family or baby? If yes, please list: \_\_\_\_\_
11. Please list any medications your baby is taking: \_\_\_\_\_
12. Does your baby have any allergies to medications? If yes, please list:  Yes  No
13. Do your baby's eyes sometimes appear to cross?  Yes  No
14. Do you ever put your baby to bed with a bottle?  Yes  No
15. Do you put sunscreen on your baby when he or she is in the sun for longer than 10 minutes?  No  Yes
16. Do you ever leave your baby alone in the house or car?  Yes  No
17. Does your baby roll over?  No  Yes
18. Can your baby sit with back support?  No  Yes
19. Does your baby pass objects from hand to hand?  No  Yes
20. Does your baby look at his or her hands?  No  Yes
21. Does your baby babble?  No  Yes
22. Does your baby sleep through the night?  No  Yes
23. Does your child live with both parents?  
Who else lives in your home? \_\_\_\_\_  No  Yes
24. Is your baby in day care?  
Who else takes care of your baby? \_\_\_\_\_  Yes  No
25. Has your baby ever had a reaction to a vaccine (such as a high fever)?  Yes  No

### CLINIC COUNSELING

- Questionnaire Reviewed
- Pertinent Topics Discussed and Advice Given

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Sign: \_\_\_\_\_