OBERLIN ROAD PEDIATRICS

Well Child Check: 6 Month Visit

Your Child's Name: _____

Do you have any concerns about your child's behavior, learning, or development? If yes, please describe:

_____

_____

Does your baby take any medications or supplements, including vitamins? □ No □ Yes: _____

Does your baby have known allergies to foods/medicines? □ No □ Yes: _____

Do you have concerns about your baby's hearing/vision? □ No □ Yes: _____

Does your baby see any specialists outside of ORP? □ No □ Yes: _____

Does your water contain fluoride? (City water contains fluoride) □ Yes □ No

Tuberculosis screen:

Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis result? □ No □ Yes

Was your child or any household member born in or traveled to a high-risk country (This includes countries in Africa, Asia, Latin America, and Eastern Europe)? □ No □ Yes

Nutrition:

Does your baby drink breastmilk, iron fortified formula, or both? □ Breastmilk □ Formula □ Both

If you are giving your baby bottles, how many ounces does your child take in 24 hours? _____

Has your baby started taking purees? □ Yes □ Not yet

If yes, circle what allergens they have tried: dairy egg fish wheat peanut butter and nut butters

Development: Does your child….

Know familiar people?	Yes	No
Like to look at himself in the mirror?	Yes	No
Laugh or makes squealing noises?	Yes	No
Take turns making sounds with you?	Yes	No
Blows "raspberries" (sticks tongue out and blows)?	Yes	No
Put things in her mouth to explore them?	Yes	No
Reach for objects?	Yes	No
Close her lips to show she does not want more food?	Yes	No
Roll from his tummy to his back?	Yes	No
Push up with straight arms when on her tummy?	Yes	No
Sit, or sit with support from leaning on arms?	Yes	No

Social Update:

Who lives at home with your child? _____

Are parents: single married divorced separated
Who takes care of your child during the day? _____

Have there been major changes lately in your baby's or family's life? □ No □ Yes_____
Do you have any international travel plans prior to your child's first birthday with your child?
If so, when and where? _____

Are you happy with your child's sleep?	Yes	No
Does anyone smoke or vape in your home?	No	Yes
Is a TV, computer, or tablet on in the background when your baby is in the room?	No	Yes
Does you baby play on a tablet or smartphone or watch TV?	No	Yes
Do you have a daily routine for feeding, naps, and bedtime?	Yes	No
Is your baby learning to go to sleep by himself?	Yes	No
Can your baby calm herself?	Yes	No
Do you have ways to calm your baby when he is crying?	Yes	No
Do you and your baby enjoy quiet activities such as reading, singing, or taking walks outside?	Yes	No
Do you always place your infant to sleep on the back?	Yes	No
Does the baby always sleep in a crib or bassinet?	Yes	No
Is your baby fastened securely in a rear facing care seat in the back seat every time they ride in the car?	Yes	No
Is your water heater set so the temperature is at or below 120 degrees F?	Yes	No
Do you always stay within arm's reach of your baby when on the changer, bed or in/near water?	Yes	No
Do you keep household cleaner, chemicals, and medicine locked up and out of your baby's sight and reach?	Yes	No
Do you have a gate at the top and bottom of all stairs in your home?	Yes	No
Is permanent housing a concern for you?	No	Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	Yes	No
Does your home have enough heat, hot water, and electricity?	Yes	No
Do you have health insurance for yourself and your baby?	Yes	No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	No	Yes
Has your partner or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	No	Yes

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never