6 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's...

1. Excessive spitting, vomiting, or back arching with feedings? ☐ Yes ☐ No
2. Congestion or wheezing? ☐ Yes ☐ No
3. Skin color or rashes (circle one)? ☐ Yes ☐ No
4. Crying more than 3 hours a day? ☐ Yes ☐ No
5. Overall development? ☐ Yes ☐ No
6. Bowel Movements: Does your baby have stool that is pale, gray, blood streaked or less than once every 5 days? ☐ Yes ☐ No

Answer the following:

7. Were there any problems with your child's second set of immunizations? ☐ Yes ☐ No
8. Is your child exposed to tobacco smoke? ☐ Yes ☐ No
9. Have you been depressed or crying excessively? ☐ Yes ☐ No
10. Does your baby co-sleep with you? ☐ Yes ☐ No
11. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No
12. Is your water source from a well? ☐ Yes ☐ No

Does your child...

13. Coo, squeal, babble, and imitate sounds? ☐ Yes ☐ No
14. Show response to his/her name? ☐ Yes ☐ No
15. Cry when you walk out of the room? ☐ Yes ☐ No
16. Seem to hear well? ☐ Yes ☐ No
17. Move all extremities equally well? ☐ Yes ☐ No
18. Roll over both ways? ☐ Yes ☐ No
19. Sit unassisted for a brief time? ☐ Yes ☐ No
20. Try to bat at objects? ☐ Yes ☐ No
21. Bear weight on both legs? ☐ Yes ☐ No

Answer the following:

22. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
23. Are you getting enough rest? ☐ Yes ☐ No
24. Does your child ride in a rear-facing infant car seat? ☐ Yes ☐ No
25. Do you know infant CPR? ☐ Yes ☐ No
26. Does your baby sleep with a pacifier? ☐ Yes ☐ No
27. Does your baby sleep on his/her back? ☐ Yes ☐ No
28. Have both parents/caregivers had the Tdap vaccine? ☐ Yes ☐ No
29. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season? ☐ Yes ☐ No
30. Bottle fed infants: Is your child getting over 30 ounces per day? ☐ Yes ☐ No

6 Month Questionnaire

Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

1. Are you giving a multivitamin with iron? ☐ Yes ☐ No
2. Breast feeding mothers, are you taking a multivitamin with iron? ☐ Yes ☐ No
3. Are you having any problems nursing? ☐ Yes ☐ No
4. Do you need help from our lactation specialists? ☐ Yes ☐ No
5. Do you need help with preparations to return to work? ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ☐ Yes ☐ No
2. Do any family members have a positive TB test? ☐ Yes ☐ No
3. Was your child or any family member born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk? ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your infant is less than 12 months old with chronic lung or congenital heart disease ☐ Yes ☐ No
2. Your infant was a preemie of 28 weeks or less and is less than 12 months old ☐ Yes ☐ No
3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months ☐ Yes ☐ No
4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder ☐ Yes ☐ No
5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise ☐ Yes ☐ No
6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant ☐ Yes ☐ No

Lead Screening:

Does your child...

1. Live in or regularly visit a house that was built before 1950? (Daycare, Babysitter, or relative) ☐ Yes ☐ No
2. Live in or regularly visit a house built before 1978 with recent ongoing renovations or remodeling (within the last 6 months)? ☐ Yes ☐ No
3. Have a sibling or playmate who now has or did have lead poisoning? ☐ Yes ☐ No
4. Is your child a refugee from another country? ☐ Yes ☐ No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ☐ Yes ☐ No

_____

_____

_____