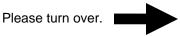
KAISER PERMANENTE	®
Six Months • Well Child Visit	

Name:

Please answer the following questions and hand this form to the clinical assistant. Your answers will help your doctor choose the best topics to discuss with you during your visit today. Skip any questions that you don't understand or that do not apply. This information is confidential.

What would you like to discuss with your doctor today?								
1.	Since your last visit, have there been any MAJOR illnesses,							
١.	hospitalizations, changes or stresses for your family or baby?		Yes		No			
2.	Is your baby taking a vitamin supplement?		No		Yes			
3.	Has your baby ever had a reaction to a vaccine (such as a high fever)?		Yes		No			
4.	Do you have any concerns with your baby's bowel movements or urination?		Yes		No			
5.	Do you put your baby to sleep with a bottle of formula or juice?		Yes		No			
6.	Do you have concerns about your baby sleeping through the night?		Yes		No			
7.	Do your baby's eyes sometimes appear to cross?		Yes		No			
8.	Do you do play with your baby every day?		No		Yes			
9.	Do you do read to your baby every day?		No		Yes			
10.	Is there a TV in your baby's bedroom?		Yes		No			
SAFETY								
11.	Have you moved your crib mattress to a lower level so your baby can't climb out?		No		Yes			
12.	Do you ever leave your baby alone at home or in a car?		Yes		No			
13.	Do you own a mobile baby walker?		Yes		No			
14.	Do you keep all medications, house cleaning products, and poisons in a cabinet out of reach?		No		Yes			
15.	Do you have the poison control center phone number available?		No		Yes			
16.	Do you place your baby in a car seat facing backwards, in the back seat?		No		Yes			
17.	Do you put sunscreen on your baby when he or she is outside for more than 10 minutes?		No		Yes			
DEV	ELOPMENT							
18.	Does your baby turn to see where sound has come from?		No		Yes			
19.	Does your baby roll over?		No		Yes			
20.	Can your baby sit with back support?		No		Yes			
21.	Does your baby reach for objects and hold on to them?		No		Yes			
22.	Does your baby pass objects from hand to hand?		No		Yes			
23.	Does your baby look at his or her hands?		No		Yes			
24.	Does your baby follow you with his or her eyes?		No		Yes			
25.	Does your baby babble?		No		Yes			



Directions

- If you have not completed the following questionnaire for Kaiser Permanente on behalf of your child, please complete the survey below.
- If you have completed this survey on behalf of your child during a previous visit, you do not need to fill this
 out again.

Lead Screening							
1.	Does your child have a sibling or playmate who has or had lead poisoning?		Yes		No		
2.	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently (within the past 6 months) been renovated or remodeled?		Yes		No		
3.	Does your child live in or regularly visit a house or child care facility built before 1950?		Yes		No		
Tuberculosis Screening							
1.	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?		Yes		No		
2.	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?		Yes		No		
3.	Has a family member or contact had tuberculosis or a positive tuberculin skin test?		Yes		No		
4.	Is your child infected with HIV or exposed to someone who is infected with HIV?		Yes		No		