# 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?**

| # | Question | | |
|---|---|---|---|
| 1. | Since your last visit, have there been any MAJOR illnesses, 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**

| # | Question | | |
|---|---|---|---|
| 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 |

**DEVELOPMENT**

| # | Question | | |
|---|---|---|---|
| 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 |

Please turn over.

**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**

| | Question | | |
|---|---|---|---|
| 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**

| | Question | | |
|---|---|---|---|
| 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 |