Pediatric Health Maintenance: 6 Months

Parent Questionnaire

Patient Information	
First & Last Name:	
Preferred Name:	
Date of Birth:	

General Health		☐ I have a concern I'd like to discuss
☐ Yes	☐ No	Is your child in daycare or the care of a babysitter?
☐ Yes	☐ No	Do your child's eyes ever appear to cross or drift apart?
☐ Yes	☐ No	Is there a family history of "lazy eye"?

Feeding and Sleeping		☐ I have a concern I'd like to discuss
What is your baby fed?		☐ Breastmilk ☐ Formula (type):
Ounces per feeding (if bottle fed):		
My baby feeds every _________ hours during daytime and is usually up ________ times during the night to feed.		
Any vitamins?		☐ Vitamin D ☐ Iron ☐ Other:
☐ Yes	☐ No	Has your baby started solid foods?
☐ Yes	☐ No	Is there fluoride in your water? ☐ Don't Know
☐ Yes	☐ No	Do you think your baby's bowel movements are normal?
☐ Yes	☐ No	Does your baby sleep through the night?

Development		☐ I have a concern I'd like to discuss
☐ Yes	☐ No	Is your baby almost able or able to sit alone?
☐ Yes	☐ No	Can your baby roll over at least one way?
☐ Yes	☐ No	If you talk to your baby, does he or she seem to "talk" back to you?
☐ Yes	☐ No	Does your baby smile, laugh, and squeal?
☐ Yes	☐ No	Does your baby reach for objects?
☐ Yes	☐ No	Does your baby seem to recognize you or other caregivers?

Safety		☐ I have a concern I'd like to discuss
☐ Yes	☐ No	Does your home have functioning smoke detectors?
☐ Yes	☐ No	Have you started to baby-proof your home?
☐ Yes	☐ No	Does your child ride in a rear-facing infant car seat, in the back seat?
☐ Yes	☐ No	Are there any smokers in your home?
☐ Yes	☐ No	Are you afraid of your partner or anyone close to you?
☐ Yes	☐ No	Do you feel overly stressed or unsupported?

Specific Concerns/Questions you wish to discuss at visit

Completed by (name and relationship to patient) Date (month/day/year)

PATIENT NAME & ID #

VIRGINIA MASON MEDICAL CENTER – Seattle WA
Pediatric Health Maintenance – 6 Months
CNPEDWLLCK
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