



6 Month Well Baby Questionnaire

Office Use Only

VFC: [] V02 -- MDD
 [] V03 -- No Ins
 [] V04 -- Native
 [] V07 -- AVAP

INSURANCE:

Copay / Co-ins

Statement Balance

Office Use Only

WT: _____

HT: _____

OFC: _____

Temp: _____

Resp: _____

Pulse: _____

Oxygen: _____

Note that "well child visits" are a form of preventative medicine, meant to catch any potential problems in a child's physical or developmental health. Each exam is tailored to the child's age, and may include necessary immunizations, vision, hearing, and developmental screenings. If your child requires significant medical intervention or you request noteworthy management changes to existing chronic problems during this appointment, this may go above and beyond a preventative exam and may be coded and billed accordingly with your insurance, in which case your financial responsibility may also change.

Child's Name: _____ **Birth Date:** _____

Do you have any concerns about your baby today? _____

Any allergies to medicine, latex, etc? Yes / No. Which ones? _____

Has your baby had any difficulty with past immunizations? Yes / No. If yes, which ones? _____

Has your baby had any surgeries? Yes / No. If yes, describe: _____

Has your child been hospitalized overnight? Yes / No. Is yes, why: _____

Is your baby on any medicine or vitamins? Yes / No. Which ones/dose? _____

Health: Is your baby exhibiting any of the following symptoms?

Ear Pain / Ear Pulling Yes / No. If yes, how long? _____ | Fever Yes / No. If yes, how long _____

Ear Drainage Yes / No. If yes, how long? _____ | Swelling Yes / No. If yes, how long _____

Eye Drainage Yes / No. If yes, how long? _____ | Cough Yes / No. If yes, how long _____

Decreased Appetite Yes / No. If yes, how long? _____ | Vomiting Yes / No. If yes, how long _____

Constipation / Gas Yes / No. If yes, how long? _____ | Diarrhea Yes / No. If yes, how long _____

Urinary Symptoms Yes / No. If yes, how long? _____ | Rash Yes / No. If yes, how long _____

Sleep Problems Yes / No. If yes, how long? _____ | Joint Pain Yes / No. If yes, how long _____

Nutrition/Elimination:

Breast Feeding Yes / No	Formula Feeding Yes / No
How often & how long? _____	Which formula? _____
Alternating sides each feeding? Yes / No.	How many ounces & how often? _____
Pumping and using expressed breast milk (bottle)? Yes / No.	Circle your baby's water supply source: City Bottled Well.
Is mom on any medication or vitamin supplements? Yes / No. Which ones? _____	
Elimination	Solids
How many wet diapers per day?: _____	Is your baby eating any solid foods? Yes / No.
How many stools per day?: _____ Does	If yes, what kind? _____
your baby have a good urine stream? Yes / No.	How often? _____ How much (ounces/ jars)? _____
	Is your child teething? Yes / No.
	If yes, how many teeth have erupted? _____

Sleep:

How many hours does your baby sleep straight at night? _____

How many naps does your baby take each day? _____ Duration? _____

Social: (Please update any of the following that has changed since the child's last visit):

Any changes in your child's environment? (new home, pets, daycare, etc.) _____

Is this child yours by: __ birth __ adoption __ marriage (stepchild) other _____

Who lives in the household with the child? (Please list for all households if more than one) **Please specify relationship to child**

Marital status of Parents: __ married __ unmarried __ separated __ divorced __ living together __ other: _____

Does this child live with you full-time? ____ Other? (Please describe) _____

Who is the primary caretaker in the home? _____

Does anyone in the household smoke (inside or outside)? Yes / No. If yes, who? _____

Is Mom working? Yes / No. Full time / Part Time Occupation/place of work: _____

Is Dad working? Yes / No. Full time / Part Time Occupation/place of work: _____

Is your child in daycare? Yes / No. If yes, where/who? _____

Do you have any pets in your home? Yes / No. Which kind/how many? _____

Any food allergies in your family? Yes / No. If yes, who and to what? _____

Any seasonal allergies or asthma in your family? Yes / No. If yes, who and to what? _____

This form completed by: _____ Relationship to Child: _____ Today's Date _____