WELL CHILD VISIT – AGE 6 MONTHS

☐ Male ☐ Female

Name: _____ ID # _____ Age: _____ DOB: _____ ☐ **IHEBAT** ☐ **120-Day IHA**

Accompanied by: ☐ Mom ☐ Dad ☐ Relative ☐ Other: _____ **Date of Visit:**_____

Wt: lbs/oz/kg (%ile)	Ht: inches/cm (%ile)	HC: inches/cm (%ile)	Temp: F°/C°	Hct/Hgb:_____ Nurse/MA_____

HISTORY

Interim History:
- ☐ No Problems
  - ☐ Significant Illness / Injury _____
  - ☐ Medications: _____
  - ☐ Allergies: _____
  - ☐ Visits to other health care provider: (name) _____

Social / Family History:
- ☐ No interval changes
  - ☐ Divorced / Single Parent
  - ☐ Child care Type:_____

Changes since last visit:_____

Nutrition: ☐ Breast ☐ Bottle ☐ Cup
Formula _____ Oz/day _____
Solid foods _____
_____
Water _____ Vitamins/Fluoride _____

Elimination: ☐ NL _____
_____
Sleep: ☐ NL _____
_____
Behavior: ☐ NL _____

Toxic exposure: Lead ☐Yes ☐No Passive Smoking ☐Yes ☐ No
TB risk: ☐ High ☐ Low

DEVELOPMENTAL HISTORY (✓ if within Normal Limits)

- ☐ Sits briefly, leaning forward
- ☐ Rolls over both ways
- ☐ Transfers objects from hand to hand, reaches for objects
- ☐ Stands when placed
- ☐ Turns to voices
- ☐ Babbles, laughs & squeals
- ☐ Plays by making sounds
- ☐ Shows pleasure with interaction from parents or others
- ☐ Transfers objects from hand to hand
- ☐ May have first tooth

PHYSICAL EXAM (✓ if within Normal Limits)

NL		Comment if Abnormal
☐	General Appearance	
☐	Skin	
☐	Head	
☐	Eyes / Appears to see	
☐	Ears / Appears to hear	
☐	Nose	
☐	Mouth and Throat	
☐	Teeth	
☐	Neck	
☐	Lungs	
☐	Heart	
☐	Femoral Pulses	
☐	Abdomen	
☐	Genitalia	
☐	Ext/Hips	
☐	Back (Scoliosis)	
☐	Neurologic	

ASSESSMENT

- ☐ Well Child

ANTICIPATORY GUIDANCE / EDUCATION (✓ if discussed or handout given)

- ☐ Breastfeed, iron-fortified formula
- ☐ Solid foods, types and amounts, no honey
- ☐ Start cup for water, juice
- ☐ Exploration opportunities
- ☐ Bedtime routine
- ☐ Pat-a-cake, peekaboo
- ☐ Use distraction as discipline
- ☐ Car seats, smoke detectors
- ☐ Injury prevention, falls, water, burns, guns
- ☐ Childproof home, poisons, hanging cords, electrical outlets
- ☐ No baby walkers
- ☐ Supervise eating
- ☐ Sunscreen
- ☐ Talk, sing, read, play music

REFERRALS / AUTHORIZATIONS

- ☐ WIC ☐ Vision Referral
- ☐ CCS
- ☐ Counseling
- ☐ Specialist (name) _____

IMMUNIZATIONS / LABORATORY

- ☐ DTaP ☐ IPV ☐ PCV ☐ Hct/Hgb
- ☐ Hib ☐ Hep B
- ☐ Other: _____ ☐ _____
- ☐ Vaccine Information Statements (VIS) given to patient

Plan: 1. **NEXT VISIT AT AGE 9 Months**
2.
3.

10/03

Signature_____**MD/DO/NP/PA Date**:_____