WELL CHILD – 6 months	Name: ☐ Female ☐ Male
Visit Date: ___/____/____	DOB: ____/____/____ Age: _____
Language: ☐ English Other:	☐ Interpreter used – Name:

T:	P:	RR:	H.C.	Length: in.	Weight: lb.	☐ Growth charts completed

Reason for visit: ☐ well visit

Allergies: | **Signature/ Title:**

INTERVAL HISTORY: ☐ Exposure to tobacco smoke

Diet: ☐ breast ☐ formula **WIC:** ☐ Yes ☐ No

Solid foods:

Appetite: **TB risk:** ☐ No ☐ Yes

Elimination:

Sleep:

Illnesses:

Childcare:

PARENTAL CONCERNS

GROWTH and DEVELOPMENT

☐ Begins to creep/crawl	☐ Transfers objects hand to hand
☐ Bears weight on legs	☐ Attempts to pull self up
☐ Gums, teethes objects	☐ Mama/dada indiscriminately
☐ Sits without support	☐ Feeds self crackers

EDUCATION / ANTICIPATORY GUIDANCE: *Check if discussed*

Diet	☐ introduction to solids ☐ appropriate weight
Safety	☐ car seat ☐ household safety ☐ walkers ☐ fall prevention ☐ childproofing ☐ sun screen
Guidance	☐ teething ☐ mobility ☐ language stimulation ☐ fever ☐ spoiling ☐ sleep schedule ☐ bottle mouth prevention ☐ dental care ☐ family dynamics ☐ parental time out

PHYSICAL EXAMINATION – *note required for all not WNL*

General Appearance	☐ well nourished and developed ☐ no abuse/neglect evident	**Heart**	☐ regular rhythm ☐ no murmur
		Femoral pulses	☐ normal bilaterally
Head	☐ symmetrical ☐ AF open _____ cm	**Abdomen**	☐ soft, no masses ☐ liver & spleen normal
Eyes	☐ red reflex L R ☐ no strabismus ☐ vision grossly normal	**Genitalia**	☐ grossly normal
		male:	☐ circumcised ☐ testes in scrotum L R
Ears	☐ canals clear ☐ TMs normal ☐ hearing grossly normal	**Spine**	☐ normal, no sacral dimple
		Extremities	☐ no deformities, full ROM
Nose/ mouth	☐ patent ☐ MM pink, no lesions	**Hips**	☐ good abduction, no clicks
Neck	☐ supple / no masses	**Skin**	☐ clear, no significant lesions
Lungs	☐ clear to auscultation bilaterally	**Neurologic**	☐ normal tone ☐ normal DTR's

Comments:

ASSESSMENT:	PLAN:

ORDERS: ☐ Vaccine reactions, risks and follow-up explained /VIS sheets given ☐ Immunization registry entry

Immunizations- ☐ DTaP ☐ Hib ☐ IPV ☐ Prevnar ☐ Rotavirus ☐ Influenza *(@ 6 mos)* ☐ Hep B

Labs:

Fluoride - ☐ Rx. 0.25 mg qd - refill until age 2 ☐ Fluoride varnish

REFERRAL: ☐ WIC Other: _____ ☐ PM 160 completed

Next appointment: ☐ 3 months Other: _____ **Provider Signature:** _____