# PEDIATRIC HEALTH MAINTENANCE – 6 Months

## Parent Questionnaire

### General

Do you have any concerns or questions you would like to discuss today? ______ No ______ Yes

If yes, please specify: ____________________

Is your child in daycare or the care of another person outside of parents? ______ No ______ Yes

Do your child's eyes ever appear to cross or drift apart ______ No ______ Yes

Is there a family history of lazy eye? ______ No ______ Yes

### Feeding and Sleeping

What is your baby fed? ☐ Breastmilk ☐ Formula (brand/type) ____________________

Ounces per feeding (if bottle fed): ____________________

My baby feeds every ______ hours daytime and is usually up ______ times during the night to feed.

Are you giving your baby any vitamins? ☐ No ☐ Vitamin D ☐ Iron ☐ Other ____________________

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? ______ Yes ______ No

### Development

Does your child like to look at themself in a mirror? ______ Yes ______ No

Does your child laugh? ______ Yes ______ No

Does your child put things in their mouth to explore them? ______ Yes ______ No

Does your child reach to grab a toy they want? ______ Yes ______ No

Does your child roll from tummy to back? ______ Yes ______ No

Does your child push up with straight arms when on their tummy? ______ Yes ______ No

Does your child lean on their hands to support themself when sitting? ______ Yes ______ No

Please share concerns you have about your child's development ____________________

### Safety

Does your home have functioning smoke detectors? ______ Yes ______ No

Have you started to babyproof your home? ______ Yes ______ No

Does your child ride in a rear-facing car seat, in the back seat? ______ Yes ______ No

Are there smokers in your home? ______ No ______ Yes

Do you have a firearm in your home? ______ No ______ Yes

If YES, is your firearm stored unloaded with the gun and ammunition locked separately and where a child cannot access them? ______ Yes ______ No

Are you afraid of your partner or anyone close to you? ______ No ______ Yes

Do you feel overly stressed or unsupported? ______ No ______ Yes

____________________ Completed by (name and relationship to patient)

____________________ Date (month/day/year)

PATIENT NAME

**VIRGINIA MASON FRANCISCAN HEALTH**

Pediatric Health Maintenance – 6 Months

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