6 Month Health Maintenance Form

Patient Name ____

Who accompanied child today? ____
(name and relationship to child)

Who does child live with? ____

Any Chronic health problems? ____

Concerns about the above health problems? ____

New or recent health concerns? ____

Feedings:
Breastfeeding:
Is Breastfeeding going well? ____

Bottle Feeding:
How many ounces per day? ____

Brand of Formula used? ____

Any juices or solids started? ____

If yes, what type? ____

Any concerns with stooling or urination? ____

Sleep pattern:
Average number hours of sleep in 24 hours? ____

Frequency of nighttime awakenings? ____

Number of naps? ____

Length of naps? ____

Turn Over Please

If you do not understand any of these questions, please ask your nurse.

Where does your child sleep? ____

Are there any smokers in the household? ____

Medications:
Please list current medications: ____

____

____

Any allergies to medicine? ____

____

Does your baby:

Roll over both ways?	Yes	No
Sit up and brace them self forward?	Yes	No
Reach for and grasp objects?	Yes	No
Transfer objects from one hand to the other?	Yes	No
Turn to the direction of sound?	Yes	No
Have stranger anxiety?	Yes	No
Rake with hands to pick up a tiny object?	Yes	No

How many children's board books do you have at home?

1. 0
2. 1-3
3. More than 3

In a week, how many times do you read or look at books with your child?

1. 0
2. 1-3
3. 3-5
4. Almost every day

If you do not understand any of these questions, please ask your nurse.