6 Month Pre-Visit Questionnaire

***Instructions*:** Please answer the questions below about your child by circling or putting an X on the correct choice. These questions help us assess the health, development, and safety of your child.

General Health		
1. Do you have any concerns about your baby?	NO	YES
2. Does your baby ever appear cross-eyed?	NO	YES
3. Skin color or skin rash concerns?	NO	YES
4. Severe nasal congestion?	NO	YES
5. Wheezing?	NO	YES
6. Any problems with previous immunizations?	NO	YES
Feeding/Nutrition		
7. Is your child breastfeeding well?	YES	NO
a. How often?		
b. For how long (minutes)?		
8. Is your child taking formula well?	YES	NO
a. How often?		
b. How many ounces?		
c. Which formula?		
9. Are you giving baby solid foods?	YES	NO
10. Giving any vitamins or supplements?	YES	NO
Oral Health		
11. Are cavities a problem for you or anyone in your family?	NO	YES
12. Does your child sleep with a bottle?	NO	YES
13. Does your baby wake at night to eat?	NO	YES
14. Are you using a soft toothbrush or cloth to clean baby's teeth?	YES	NO
15. Does your water contain fluoride or is your child on a fluoride supplement?	YES	NO
Elimination		
16. Problems with bowel movements (pooping)?	NO	YES
17. Concerns about urination (peeing)?	NO	YES
Sleep		
18. Sleeps at least six to eight hours at a time?	YES	NO
19. Baby falls asleep on his/her own?	YES	NO
20. Do you have a bedtime routine?	YES	NO
Social Stressors		
21. Are you able to take a little time for yourself?	YES	NO
22. Has mother been sad or crying a lot? Feeling down, depressed, or hopeless?	NO	YES
23. Any major changes or stresses in your family recently?	NO	YES
24. Do you ever worry your family will go hungry?	NO	YES
25. Do you have daycare concerns?	NO	YES

Development

26. Babbling and imitating sounds?	YES	NO
27. Responds to his or her name?	YES	NO
28. Rolling over both ways?	YES	NO
29. Makes eye contact?	YES	NO
30. Reaches for things?	YES	NO
31. Sits unassisted for a few seconds?	YES	NO
32. Do you read to your baby every day?	YES	NO
33. Do you play games like peek-a-boo or play music with your baby?	YES	NO
34. Are you starting to work with a sippy cup?	YES	NO

Safety

35. Do you always keep a hand on baby when placed above the floor?	YES	NO
36. Does baby wear any jewelry (including necklaces)?	NO	YES
37. Is infant exposed to anyone who smokes?	NO	YES
38. Home has working smoke detectors and carbon monoxide detectors?	YES	NO
39. Do you ever hold or carry hot liquids around the baby?	NO	YES
40. Do you keep plastic bags and latex balloons away from your baby?	YES	NO
41. Infant rides in a rear-facing safety seat, in the back seat?	YES	NO
42. Water heater turned to below 120 degrees?	YES	NO
43. Barriers around space heaters, wood stoves, etc.?	YES	NO
44. Household cleaners, chemicals, and medicines locked up?	YES	NO
45. Baby uses a seated infant walker?	NO	YES
46. Are you using sunscreen if your baby is in the sun for more than 10 minutes?	YES	NO

Tuberculosis

47. Has a family member or contact had tuberculosis disease?	NO	YES
48. Has a family member had a positive TB skin test (PPD)?	NO	YES
49. Was your child born in a high-risk country (countries other than the U.S., Canada, Australia, or Western Europe)?	NO	YES
50. Has your child traveled to a high-risk country for more than a week?	NO	YES