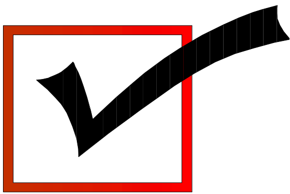

WELL CHILD VISIT

6 Month

Name ________________________________ Age in Months ____________ Date of Visit ______________________

Concerns/Discussion

☐ Feeding
☐ Stooling
☐ Sleep
☐ Family problems
☐ Illness/Accidents
☐ Other concerns
☐ Observe parent/Child interaction
☐ Separation anxiety
☐ Temperament/Parent description
____
____

Nutrition

☐ Breast ______ times/day
☐ Formula ______ bottles/day
Type ____________________
☐ Solids ______ times/day
Type ____________________

Guidance

☐ Breast or Fe fortified formula until 1 yr.
☐ Introduce cup for water & juice
☐ Fe supplement if breast only
☐ Introduction of new solids
☐ Choking hazards
☐ No bottles in crib

Developmental/Behavioral

☐ Vocalizes (“dada”,“baba”)
☐ Rolls over
☐ No head lag
☐ Sits with support
☐ Grasps and mouths objects
☐ Smiles, laughs, imitates sounds
☐ Tooth eruption

Physical Exam

☐ General
☐ Wt ______ % ______
Ht ______ % ______
HC ______ % ______
Monitor growth chart
☐ Temp ______
☐ Skin
☐ Nodes
☐ Head
☐ Eyes (Strabismus)
☐ Ears
☐ Nose
☐ Oropharynx
☐ Neck
☐ Chest/Breast
☐ Lungs
☐ Cardiovascular (murmurs)
☐ Abdomen
☐ Genitalia
☐ Hips (Clicks)
☐ Neuro (tone/strength)
☐ Evidence of Neglect/Abuse

Screening/Immunizations

Screening

☐ Hearing - exam & history
(if newborn screening completed)
☐ Vision (exam & history)
☐ Dental
- Discuss fluoride

Immunizations

☐ Per ACIP schedule (Record below)

Anticipatory Guidance

☐ Car seat
☐ Sleep safety
☐ “Baby-proof” house
☐ Bath/Water safety
☐ Choking/Poisoning safety
☐ Prevention of falls
☐ Sun exposure
☐ Lead poisoning hazards
☐ Age appropriate toys
☐ Baby “Walker” safety
☐ Parent/Infant interaction
(play, reading, etc)
☐ Illness instructions

Immunizations given:
____
____
____

Record all abnormal findings below.
____
____
____

Assessment and Plan: ____
____

PHN Referral (if indicated) ____________________ WIC Referral (if indicated) ____________________

Physician Signature: ____

Based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents

June 2001