6 Month Well Exam

Name

Room

Notes

Weight	T
Length	HR
OFC	RR
	O2

Nutrition

Question				
What type of milk does your baby drink?	Breast Milk	Formula		
Does your baby take any vitamins?	Yes	No		
Has your baby started solids?	Yes	No		
Which ones?	Grains/Cereal	Veggies	Fruits	Proteins
Does your baby eat honey?	No	Yes		

Sleep

Question		
Does your baby sleep through the night?	Yes	No
How many naps does your baby take per day?	2 or more	<2

Development

Question		
Do you feel that your baby sees well?	Yes	No
Do you feel that your baby hears well?	Yes	No
Does your baby laugh out loud?	Yes	No
Does your baby babble?	Yes	No
Can your baby pass an object from one hand to another?	Yes	No
Can your baby sit briefly with support?	Yes	No
Do you read to your baby?	Yes	No

Safety

Question		
In what position does your baby sleep?	Back	Side/Tummy
Do you use a rear-facing carseat for your baby?	Yes	No
Any smokers at home?	No	Yes

Followup D/W/M

Reason:

□EHR