Name: _____ Date of birth: _____

Health Status Questionnaire – 6 Months

Baby lives with: mother father both parents other:_____

Childcare: daycare babysitter stays at home other:_____

Breastfeeding? Y N Every ____ hours For _____ minutes per side

Formula feeding? Y N Formula:_____

____ oz every ____ hours, _____ oz total 24 hours

If at least ½ the feedings are breastmilk, giving vitamin D supplement? Y N

Solids/baby food? Y N Cereal _____ Vegetables _____ Fruit _____

Any problems feeding? Y N _____

Stool pattern: regular irregular hard runny soft

Sleep problems: Y N _____

Development concerns: none speech motor social cognitive vision hearing

Does your baby:

Sit briefly?	Y	N
Roll over both ways?	Y	N
Bear weight on legs or stand holding on?	Y	N
Keep head steady when pulled to sit?	Y	N
Reaches for objects and put in mouth?	Y	N
Transfer a toy from hand to hand?	Y	N
Babble or vocalize some consonant sounds?	Y	N
Turn his/her head to look at the source of a sound?	Y	N
Imitate sounds?	Y	N

Car seat use:	Y	N	Smoke detectors:	Y	N
Sunscreen/protection:	Y	N	Fire extinguishers:	Y	N
Home childproofed:	Y	N	Passive smoke exposure:	Y	N

Do you have any concerns about your baby? _____

_____

Updated 8/28/17