

## Your baby is 6 months old!

It's time for their check-up. Your care team at Kaiser Permanente looks forward to seeing your baby for their well visit. At this visit, we will cover many important topics to support your baby's growth, development, wellness, and safety, and we'll give your baby any needed vaccines.

Please take a moment to complete the following questions so we can provide the best care for your baby.

Well Visit Belly button Breathing Constipation Cough Development Diaper rash   Eye discharge Feeding Fever Fussiness/crying Genitals Growth/nutrition   Head shape Nasal congestion Rash Stool change Vaccines Vomiting   Other (please explain): Briefly describe your concern:	Do you have specific concerns? Check all that apply, then briefly describe your concern:		
□ Head shape □ Nasal congestion □ Rash □ Stool change □ Vaccines □ Vomiting         □ Other (please explain):         Briefly describe your concern:         Health Changes         Has your baby received any specialty or emergency care since the last visit?         If Yes, please describe:         Has your baby or anyone in the family developed a new health condition or died?         Include parents, brothers, sisters, grandparents, aunts, uncles or cousins.         If Yes, please describe:         Nutrition, Feeding and Supplements – Tell us about what your baby eats.         My baby is (check all that apply):         □ Breastfeeding         □ Other: eating/drinking anything else (please describe):         My baby receives daily Vitamin D:         Please list any other vitamins, supplements, or over-the-counter medicines you give your baby:         □ I don't know         Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.         My baby:         Responds to their name:       □ Yes □ No         Can usually be soothed (do			
□ Other (please explain):	Eye discharge Feeding Fever Fussiness/crying Genitals Growth/nutrition		
Briefly describe your concern:	🗌 Head shape 🗌 Nasal congestion 🗌 Rash 🗌 Stool change 🗌 Vaccines 🗌 Vomiting		
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Has your baby received any specialty or emergency care since the last visit?       I Yes No         If Yes, please describe:       I Yes No         Has your baby or anyone in the family developed a new health condition or died?       Yes No         Include parents, brothers, sisters, grandparents, aunts, uncles or cousins.       Yes No         If Yes, please describe:       Yes No         Nutrition, Feeding and Supplements – Tell us about what your baby eats.       Yes No         My baby is (check all that apply):       Breastfeeding Drinking pumped breast milk Drinking formula       I Yes No         Other: eating/drinking anything else (please describe):       Yes No         My baby receives daily Vitamin D:       Yes No         Please list any other vitamins, supplements, or over-the-counter medicines you give your baby:       Yes No         Does your water source have fluoride?       Yes No         Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.         My baby:       Yes No         Responds to their name:       Yes No         Responds to their name:       Yes No         Responds to their name:       Yes No         Enjoys singing, talking, and reading with me:       Yes No         Babbles using single letter sounds, like "mmm", "ba", "da", "ma":	Briefly describe your concern:		
If Yes, please describe:	Health Changes		
Include parents, brothers, sisters, grandparents, aunts, uncles or cousins.       If Yes, please describe:		🗌 Yes 🗌 No	
If Yes, please describe:	Has your baby or anyone in the family developed a new health condition or died?	Yes No	
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Breastfeeding       Drinking pumped breast milk       Drinking formula         Other: eating/drinking anything else (please describe):			
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Please list any other vitamins, supplements, or over-the-counter medicines you give your baby:       Image: Comparison of the counter medicines you give your baby:         Does your water source have fluoride?       Image: Comparison of the counter medicines you give your baby:         Infant Behavior and Development: For each of the following, think about the past few weeks. If the statement is usually or sometimes true, answer Yes, and if rarely or never true, answer No.         My baby:       Image: Comparison of the counter medicines you give your baby:         Responds to their name:       Image: Yes         Recognizes me and other family members:       Image: Yes         Can usually be soothed (does not seem fussier than other babies):       Image: Yes         Enjoys singing, talking, and reading with me:       Image: Yes         Babbles using single letter sounds, like "mmm", "ba", "da", "ma":       Image: Yes			
	My baby receives daily Vitamin D:	Yes No	
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Babbles using single letter sounds, like "mmm", "ba", "da", "ma":	Can usually be soothed (does not seem fussier than other babies):	🗌 Yes 🗌 No	
	Enjoys singing, talking, and reading with me:	🗌 Yes 🗌 No	
	Babbles using single letter sounds, like "mmm", "ba", "da", "ma":	🗌 Yes 🗌 No	
Sits briefly without being held before tipping over:	Sits briefly without being held before tipping over:	🗌 Yes 🗌 No	
Raises their chest and puts weight on straight arms when lying on their stomach:	Raises their chest and puts weight on straight arms when lying on their stomach:	🗌 Yes 🗌 No	
Moves toys from one hand to the other:	Moves toys from one hand to the other:	Yes No	
Tries to pick up small objects by raking their fingers:	Tries to pick up small objects by raking their fingers:	Yes No	
Bangs objects on a surface:	Bangs objects on a surface:	Yes No	



Vision and Hearing		
My baby's eyes track together and almost never cross:	🗌 Yes 🗌 No	
My baby follows an object or me with their eyes as it moves around:	🗌 Yes 🗌 No	
My baby turns toward sounds:	🗌 Yes 🗌 No	
Safety		
My baby rides in a rear-facing car seat in the back seat of the car for every car ride:	🗌 Yes 🗌 No	
Sleep		
My baby:		
Sleeps in a (choose all that apply):		
Crib or bassinet Shared bed Other product - please describe:		
Sleeps with arms free:	🗌 Yes 🗌 No	
Crib is free of loose blankets, toys, and pillows:	🗌 Yes 🗌 No	
Is always put to sleep on their back:	🗌 Yes 🗌 No	
Has a nap schedule and sleep routine:	Yes No	
Is usually easy to put to sleep:	🗌 Yes 🗌 No	
Sleeps for long stretches at night:	🗌 Yes 🗌 No	
Family Health and Well Being: We know that all families sometimes face challenges that can impact everyone, including children. Please answer the following questions so we can best support your family.		
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	🗌 Yes 🗌 No	
What is your plan for childcare?		
Home with parent Family member Nanny or Sitter Childcare center		
Do you need assistance finding affordable and safe childcare?	🗌 Yes 🗌 No	
Is there anyone who lives in your home or cares for your child who:		
<ul> <li>Smokes or vapes tobacco or marijuana:</li> </ul>	🗌 Yes 🗌 No	
<ul> <li>Uses prescription pain medication:</li> </ul>	🗌 Yes 🗌 No	
- Uses other drugs:	🗌 Yes 🗌 No	
<ul> <li>Consumes alcohol more than an occasional drink (a beer or glass of wine at night):</li> </ul>	🗌 Yes 🗌 No	
Within the past 12 months, have you:		
– Run out of food or been worried your food would run out before there was money to buy more?	Yes No	
– Worried about housing or had to move?	Yes No	
– Had difficulty getting other supplies and services you need to care for your baby?	Yes No	
Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.		