KAISER PERMANENTE®

Well-Visit Questionnaire
Children Age 6 Months

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.

Do you have specific concerns? Check all that apply, then briefly describe your concern:	
☐ 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:_____	
Health Changes	
Has your baby received any specialty or emergency care since the last visit? If Yes, please describe: _____	☐ Yes ☐ No
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: _____	☐ Yes ☐ No
Nutrition, Feeding and Supplements – Tell us about what your baby eats.	
My baby is (check all that apply): ☐ Breastfeeding ☐ Drinking pumped breast milk ☐ Drinking formula ☐ Other: eating/drinking anything else (please describe): _____	
My baby receives daily Vitamin D:	☐ Yes ☐ No
Please list any other vitamins, supplements, or over-the-counter medicines you give your baby: _____	
Does your water source have fluoride?	☐ Yes ☐ No ☐ 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
Recognizes me and other family members:	☐ Yes ☐ No
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:	☐ Yes ☐ No
Raises their chest and puts weight on straight arms when lying on their stomach:	☐ Yes ☐ No
Moves toys from one hand to the other:	☐ Yes ☐ No
Tries to pick up small objects by raking their fingers:	☐ Yes ☐ No
Bangs objects on a surface:	☐ Yes ☐ No

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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:	
- Smokes or vapes tobacco or marijuana:	☐ Yes ☐ No
- Uses prescription pain medication:	☐ Yes ☐ No
- Uses other drugs:	☐ Yes ☐ No
- Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	☐ 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? Examples would be crib, car seat, diapers, heating, hot water, electricity, and transportation.	☐ Yes ☐ No

NOT TO BE FILED IN THE MEDICAL RECORD

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