Reedsburg
AREA MEDICAL CENTER
Physicians Group

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Patient Questionnaire – Six-Month Well Child

Patient Name:____ Date of Birth:___/___/___ Date:_________________

History Provided By (please circle)	Mother	Stepparent	Grandmother	Aunt
	Father	Brother	Grandfather	Foster Parent
	Legal Guardian	Sister	Uncle	Caseworker
Lives With (please circle)	Mother	Stepparent	Grandmother	Aunt
	Father	Brother	Grandfather	Foster Parent
	Legal Guardian	Sister	Uncle	Caseworker
Interval Problems (please circle)	Caregiver depression	Lack of social support	Recent illness	
	Caregiver stress	Marital discord	Recent injury	
	Chronic caregiver stress at home			
Nutrition				
Milk Source (please circle)	Breastfeeding	Cow's Milk	Formula	
Additional Intake (please circle)	Solids	Water	Non-nutritional	
Feeding Problems (please circle)	Burping Poorly	Spitting Up	Vomiting	
Breast Feeding				
Frequency of Feedings (please circle)	Every 1-3 hours	Every 6-8 hours	5-8 times per 24 hours	
	Every 4-5 hours	1-4 times per 24 hours	9-12 times per 24 hours	
Side per Feeding (please circle)	One side	Both sides		
Feeding time per side (minutes) (please circle)	**Right breast:** 1-5 6-10 11-15 16-20 20+			
	Left breast: 1-5 6-10 11-15 16-20 20+			
	Ounces per 24 hours: __________			
Pumped (please circle)	Yes	No		

Please see reverse side

Formula	
Type of Formula (please circle)	Cow's milk based Low Iron Premature Extensively Hydrolyzed Metabolic Soy Lactose Free **Ounces per Feeding: ______________** **Ounces per 24 hours: ______________**
Frequency of Feedings (please circle)	Every 1-3 hours Every 6-8 hours 5-8 times per 24 hours Every 4-5 hours 1-4 times per 24 hours 9-12 times per 24 hours
Cereal	
Cereal Type (please circle)	Barley Corn Oat Rice
Solid Foods	
Types of Intake (please circle)	Fruits Meats Vegetables
Food Consistency (please circle)	Pureed Foods Stage II Foods Stage III Foods Table Foods
Dental	
Teething Symptoms (please circle)	Yes No
Tooth Eruption (please circle)	Not evident Beginning In progress Complete
Elimination	
Urinary Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours With every feeding 1-3 times per 24 hours More than 6 times per 24 hours
Stool Frequency (please circle)	Once per 24 hours 4-6 times per 24 hours Once per 48 hours 1-3 times per 24 hours With every feeding Once per 72 hours 4-6 times per 24 hours
Stool Consistency (please circle)	Formed Hard Loose Seedy Watery
Elimination Problems (please circle)	Colic Diarrhea Urinary Symptoms Constipation Gas

Sleep	
Sleep Location (please circle)	Bassinet Crib Parent's Bed
How child falls asleep (please circle)	Bottle is in crib In caretaker's arms while feeding On own In caretaker's arms
Sleep Position (please circle)	Supine (on back) On side Prone (on stomach) **Average sleep duration in hours: ___________**

Safety/Environment	
Home is child-proofed (please circle)	Yes No Partially
Smoking in home (please circle)	Yes No
Working smoke alarms (please circle)	Yes No Don't know
Working CO (carbon monoxide) alarms (please circle)	Yes No Don't know
Car seat (please circle)	Yes No

Screening			
Immunizations up-to-date (please circle)	Yes No	**Risk factors for oral health** (please circle)	Yes No
Risk factors for hearing loss (please circle)	Yes No	**Risk factors for lead toxicity** (please circle)	Yes No
Risk factors for tuberculosis (please circle)	Yes No		

Social	
Caregiver enjoys child (please circle)	Yes No
Childcare location (please circle)	Child's home Daycare Another residence
Childcare provider (please circle)	Parent Relative Babysitter Daycare provider
Days per week at daycare: _____________ **Hours per day at daycare: _____________**	

Please see reverse side

Growth and Development

Do you or your family/childcare provider have concerns about your baby's development or behavior? (please circle)

Yes No

Does your baby:

Interact with family by smiling and making sounds with voice? (please circle)

Yes No

Show a range of emotions? (please circle)

Yes No

Look you in the eye for more than a second or two? (please circle)

Yes No

Turn to a person talking? (please circle)

Yes No

Make sounds like “da”, “ba” or “ga” as well as high pitch squeals or cooing sounds? (please circle)

Yes No

Roll from tummy to back and back to tummy? (please circle)

Yes No

Reach for objects? (please circle)

Yes No

Hold neck straight when pulled up to sitting position? (please circle)

Yes No

Bear weight on legs? (please circle)

Yes No

Sit without support at least briefly? (please circle)

Yes No