ABC Pediatrics

Six Month Pre-visit Questionnaire

Patient Name_____ Date_____

Bathes: (Daily) (Every other day)

Feeding Routine (circle): Breast feeding Bottle Feeding Both

Formula: _____Ounces per feeding? _____ Every how many hours? ____

Solids: Cereals____ Rice____ Stage _____baby foods Others_____

# of stools Daily_____# of voids Daily_____ # of hours sleeping at ONE time_____

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things?_____

Have there been any major changes in your family recently other than your baby's birth?

_____

Developmental Milestones (check all that apply)

☐ Babbles	☐ Laughs	☐ Feeds Self	☐ Sits Briefly
☐ Plays peek-a-boo	☐ Turns to voice	☐ Says mama/dada	☐ Stranger Anxiety
☐ Works to get toy out of reach	☐ Rakes at food and attains	☐ Passes things hand to hand	☐ No head Lag
☐ Bares weight on legs	☐ Looks for missing objects	☐ Shows pleasure interacting with others	☐ Plays by making sounds
	☐ Says Mama/Dada		☐ Resists toy pull

Any other questions or concerns you would like to discuss?

_____

TB Screen	**Has a family member or contact been diagnosed with TB?**	**YES**	**NO**
	Was your child born in a country at high risk for TB?	**YES**	**NO**
	Has your child traveled to a country at high risk for TB?	**YES**	**NO**
Lead Risk	**Does your child have a sibling or playmate that has had lead poisoning?**	**YES**	**NO**
	Does your child live in or regularly visit a home built before 1978 that being renovated?	**YES**	**NO**
	Does your child live in or regularly visit a house or childcare facility built before 1950?	**YES**	**NO**

Weight_____ Temp_____Height_____ Head Circumference_____

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