

#### 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:	
<input type="checkbox"/> Well Visit <input type="checkbox"/> Belly button <input type="checkbox"/> Breathing <input type="checkbox"/> Constipation <input type="checkbox"/> Cough <input type="checkbox"/> Development <input type="checkbox"/> Diaper rash <input type="checkbox"/> Eye discharge <input type="checkbox"/> Feeding <input type="checkbox"/> Fever <input type="checkbox"/> Fussiness/crying <input type="checkbox"/> Genitals <input type="checkbox"/> Growth/nutrition <input type="checkbox"/> Head shape <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Rash <input type="checkbox"/> Stool change <input type="checkbox"/> Vaccines <input type="checkbox"/> Vomiting <input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nutrition, Feeding and Supplements – Tell us about what your baby eats.	
My baby is (check all that apply): <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Drinking pumped breast milk <input type="checkbox"/> Drinking formula <input type="checkbox"/> Other: eating/drinking anything else (please describe): _____	
My baby receives daily Vitamin D:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please list any other vitamins, supplements, or over-the-counter medicines you give your baby: _____	
Does your water source have fluoride?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recognizes me and other family members:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can usually be soothed (does not seem fussier than other babies):	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enjoys singing, talking, and reading with me:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Babbles using single letter sounds, like "mmm", "ba", "da", "ma":	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sits briefly without being held before tipping over:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Raises their chest and puts weight on straight arms when lying on their stomach:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Moves toys from one hand to the other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tries to pick up small objects by raking their fingers:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bangs objects on a surface:	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Vision and Hearing</b>	
My baby's eyes track together and almost never cross:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My baby follows an object or me with their eyes as it moves around:	<input type="checkbox"/> Yes <input type="checkbox"/> No
My baby turns toward sounds:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Safety</b>	
My baby rides in a rear-facing car seat in the back seat of the car for every car ride:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sleep</b>	
<b>My baby:</b>	
Sleeps in a (choose all that apply): <input type="checkbox"/> Crib or bassinet <input type="checkbox"/> Shared bed <input type="checkbox"/> Other product - please describe: _____	
Sleeps with arms free:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crib is free of loose blankets, toys, and pillows:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is always put to sleep on their back:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a nap schedule and sleep routine:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is usually easy to put to sleep:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleeps for long stretches at night:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>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.</b>	
Do you have concerns for low mood, depression, or anxiety in yourself or your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your plan for childcare? <input type="checkbox"/> Home with parent <input type="checkbox"/> Family member <input type="checkbox"/> Nanny or Sitter <input type="checkbox"/> Childcare center	
Do you need assistance finding affordable and safe childcare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is there anyone who lives in your home or cares for your child who:</b>	
- Smokes or vapes tobacco or marijuana:	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Uses prescription pain medication:	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Uses other drugs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Consumes alcohol more than an occasional drink (a beer or glass of wine at night):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Within the past 12 months, have you:</b>	
- Run out of food or been worried your food would run out before there was money to buy more?	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Worried about housing or had to move?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No