6 Month Well Exam

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A WellCare Company

Date_____ Patient #_____

Name_____ Date of Birth_____

Address_____

_____

Lives with: ☐ 1 Parent ☐ 2 Parents ☐ Other Caregiver

☐ Others (including siblings)_____

_____

May release information to (parent, guardian, other family - list):

_____

_____

Parental concerns: _____

_____

Changes in child's health since last visit:_____

_____

GENERAL HEALTH

Nutrition: ☐ Breast:_____times/day
☐ Bottle:_____ oz/day

YES	NO				
☐	☐	Drink from a cup?			
☐	☐	Juice? If so, _____oz/day			
☐	☐	Solids?	☐ Cereals	☐ Fruits	☐ Vegetables
			☐ Meats	☐ Table/fingerfoods	

Daily oral health care? ☐ Yes ☐ No ☐ No Teeth

Elimination: ☐ Stooling: soft, easy to pass BMs

Sleep:_____hours through the night

YES	NO	
☐	☐	Problems? Night feedings?_____
☐	☐	Bottle to bed?

DEVELOPMENT (Screen or refer if concerns or "No" response on milestones in **bold type)**

YES	NO	
☐	☐	**Interacts with family by smiling and vocalizing**
☐	☐	**Shows range of emotions**
☐	☐	**Turns to voice**
☐	☐	**Babbles and coos**
☐	☐	**Rolls over both ways**
☐	☐	**Reaches for objects**
☐	☐	**No head lag when pulled to sitting**
☐	☐	**Bears weight on legs**
☐	☐	May sit without support

Family concerns about growth, development, behavior

_____

_____

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY

Child care: _____

FAMILY RISK FACTORS

Changes in family since last visit:_____

_____

STRESS:

How much stress are you and your family under now?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

What kind of stress?

☐ Relationship	☐ Alcohol	☐ Drugs
☐ Violence/Abuse	☐ Lack of help	☐ Financial
☐ Health Insurance	☐ Child care	
☐ Other_____		

How stressful is caring for your child?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

MATERNAL/CAREGIVER DEPRESSION:

In the past month, have you/partner felt down, depressed or hopeless?
☐ No ☐ Sometimes ☐ **Often**

In the past month, have you/partner felt little interest or pleasure in doing things?
☐ No ☐ Sometimes ☐ **Often**

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:

☐ Encourage support system, time for self, partner, family
☐ Consistency in routines at home and in daycare

BEHAVIOR:

☐ Encourage reading, singing and talking with infant
☐ Discuss causes of fussiness - overstimulation, fatigue, boredom
☐ Sleep routine - self-calming, putting self to sleep. What to do if wakes during night

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:

☐ Feed infant based on hunger cues. Soft finger foods
☐ Avoid milk, fish, shellfish, egg whites, peanuts and nuts
☐ Limit juice < 2 oz a day. Begin sippy cup
☐ No bottles in bed, no bottle propping
☐ Smear of fluoride-containing toothpaste and soft toothbrush when teeth erupt

SAFETY:

☐ Never leave infant alone near water, on high places (changing table, couch, bed, etc.)
☐ Childproof home, barriers in front of heat sources
☐ Lower crib mattress - may pull to stand, back to sleep, no loose bedding
☐ Poison control on every phone: **800-222-1222**
☐ If smoking in home: discuss quitting, limiting exposure

Revised June 2012

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MEDICAL HISTORY

Name _____ Date of Birth _____

Allergies _____ Medications _____

Major medical illnesses/special health care needs _____

Hospitalizations/Surgeries _____

PHYSICAL EXAMINATION (UNCLOTHED)

☐ Vision Evaluation
☐ Hearing Evaluation

Vital Signs: P:_____R:_____T:_____Weight:_____(_____%)

Length _____(_____%) Wt/Length _____% Head circumference _____(_____%)

Review of Systems

N	Abn	N	Abn		*Comment on abnormal findings*
☐	☐	☐	☐	General appearance	
☐	☐	☐	☐	Behavior/interaction with family	
☐	☐	☐	☐	Skin	
☐	☐	☐	☐	Head/scalp	
☐	☐	☐	☐	Ears	
☐	☐	☐	☐	Eyes	
☐	☐	☐	☐	Nose	
☐	☐	☐	☐	Mouth/throat	
☐	☐	☐	☐	Teeth	
☐	☐	☐	☐	Neck	
☐	☐	☐	☐	Back/chest	
☐	☐	☐	☐	Lungs	
☐	☐	☐	☐	Heart	
☐	☐	☐	☐	Abdomen	
☐	☐	☐	☐	Genitalia	
☐	☐	☐	☐	Musculoskeletal	
☐	☐	☐	☐	Neurological	

Results reviewed (outside info, lab, etc.) _____

Impression _____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent

Past adverse reaction to immunizations: ☐ Yes ☐ No

☐ Vaccines given ☐ Vaccines refused _____

Lab (if indicated) _____

Developmental follow-up ☐ No delays ☐ Follow-up in office ☐ Referral

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated) _____

Handouts _____

Return appointment _____

Signature _____ Date _____

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