



Well Child Health Screen: 4-6 Months

Name: _____ Birthdate: _____ Visit Date: _____

General Health Updates

Who is completing this form?	<input type="checkbox"/> Mom <input type="checkbox"/> Dad <input type="checkbox"/> Other, please list:
Any questions, concerns, or problems you want to discuss today?	
Any updates to the patient's health? (i.e. new conditions, surgeries, etc.)	
Any family health, family status or social updates we should be aware of?	
Any concerns about development, learning or behavior?	
Who lives with the patient?	
Any smoke or e-cigarette exposure?	
Anything else you want to share? (milestones, proud moments, etc.)	

Development

The following section is used to make sure they are developing normally. Each set of milestones is generally achievable by 75% of children of the same age. If you have questions/concerns, please talk to your provider.

If they are nearest 4 months , check the items they can do most of the time:	<input type="checkbox"/> Holds head steady without support when you are holding them	
	<input type="checkbox"/> Holds a small toy in their hand	
	<input type="checkbox"/> Brings hands to mouth	
	<input type="checkbox"/> Pushes up onto elbows/forearms when on tummy	
	<input type="checkbox"/> Makes sounds like "oooo", "aahh" (cooing)	
	<input type="checkbox"/> Looks at you, moves, or makes sounds to get or keep your attention	
If they are nearest 6 months , check the items they can do most of the time:	<input type="checkbox"/> Knows familiar people	<input type="checkbox"/> Takes turns making sounds with you
	<input type="checkbox"/> Reaches to grab a toy they want	<input type="checkbox"/> Rolls from tummy to back
	<input type="checkbox"/> Pushes up with straight arms when on tummy	

Health Risk Screening

The following questions may prompt your provider to complete further testing, depending on the answer. Ask your provider if you have any questions about these health screening questions.

Do you have concerns about their eyes or vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have concerns about their hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Life

Are there barriers that prevent you from spending time each day interacting with them?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone in the home/family have problems with drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline

Nutrition

What are they eating?	<input type="checkbox"/> Breastmilk <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> Other, describe:
Do you have concerns or questions about what or how they are eating?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Oral Health

Does anyone in the house have current dental decay/cavities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Do they take extra fluoride OR drink water that contains fluoride?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Sleep

Healthy sleep is important for growth, development, and learning. Infants and toddlers may sleep 15-18 hours in a day, while school-aged children should be getting more than 10 hours a day. We do not recommend having a screen in their bedroom as this can affect sleep.

Where do they sleep?	<input type="checkbox"/> Crib <input type="checkbox"/> Bed <input type="checkbox"/> Co-sleep <input type="checkbox"/> Other:
Do you put them to sleep on their back?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Safety

Is the baby riding in a rear-facing car safety seat in the backseat every time in a vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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