

6 MONTH WELL CHILD VISIT

Hirsch Holistic Family Medicine

3525 Ensign Rd NE Ste N

Olympia WA 98506 (360) 464-9965 / (800) 897-8320 fax

Patient name: _____ Birthdate _____ Age _____

Accompanied by: _____ Date _____

PARENT SECTION: Please check yes or no and fill in the blanks.

GENERAL ISSUES

Yes o No o Overall, I feel confident that my baby is doing well
Yes o No o I have enough help with the baby
Who lives with you and the baby?
Who cares for your baby during the day?
How would you describe your baby's personality?

FEEDING/SLEEPING

No o Yes o I have questions about my baby's feeding
My baby takes breast milk every _____ hrs, or
_____ Formula, _____ oz, every _____ hrs
What solid food has your baby tried?
Yes o No o I am satisfied with my baby's sleep schedule
Longest sleep period: Daytime _____ Nighttime _____
How do you get your baby to sleep?
Feeding / Rocking / Pacifier / Self / Other
Where does your baby sleep?
No o Yes o I have questions about teething

VOIDING AND STOOLING

No o Yes o My baby pees and poops normally
Wet diapers _____ Stool diapers _____ per day

DEVELOPMENT

No o Yes o I have questions about my baby's development
My baby recognizes his/her name
My baby babbles
My baby laughs and squeals
My baby sits alone
My baby can change a toy from one hand to the other
My baby plays peek-a-boo

PREVENTION

No o Yes o My baby lives with someone who smokes cigarettes
No o Yes o My child or another person living with us was born outside the
U.S. or has traveled to Asia, Mexico, Latin America, or Africa.
No o Yes o I have a family member who has had Tuberculosis
Yes o No o I always keep my baby in the car seat when driving
Yes o No o My baby sleeps only on his/her side or back
Yes o No o I have smoke detectors at home
Yes o No o My hot water heater is set to 120°F
Yes o No o My house is "child-proofed"
Yes o No o I know the number for Poison Control (1-800-222-1222)
No o Yes o I have questions about immunizations/shots
Yes o No o I know how to take a temperature and treat a minor cold
No o Yes o Are there any other issues you want to discuss today?

DISCUSSION TOPICS

General questions
Parenting support

Iron source by 6 months
Continue breastfeeding
Avoid bottle propping
Safe foods/foods to avoid
Normal sleep range 2-8 hours
Safe sleep environment
Avoid bedtime bottle
Bedtime routines
Nighttime crying
Transitional object
Teething, cleaning teeth
Thumb sucking

Normal variation

R-PDQ if concerns
Key social milestone
Anticipate crawling
Stranger anxiety
Books and music

Risk of tobacco exposure
Assess TB risks
No exceptions with car seat
SIDS prevention
Smoke detector maintenance
Burn prevention, crib safety,
choking, cleaning sln's &
meds up high, no walkers
Mr. Yuck stickers
Injuries #1 cause of death
Everything to the mouth

PHYSICAL EXAM: (All items examined unless crossed out. Abnormalities circled and commented on)

Mortality leaders: accidental injury, falls, burns, auto accidents, choking, drowning

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Height: _____ cm (_____ %)
 Weight: _____ kg (_____ %)
 OFC: _____ cm (_____ %)
 T: _____
 P: _____
 RR: _____

General Appearance: Alert, no apparent distress, social _____
 Skin: No lesions _____
 Head/Fontanelles: Normocephalic, AF _____ x _____
 EENT: conjunctiva clear, normal cover test, _____
 TMs pearly, nares patent, normal oral mucosa _____
 Lungs: Clear bilaterally _____
 CV: Normal S1, S2, RRR without murmur, _____
 normal femoral pulses _____
 Abdomen: Soft, no hepatosplenomegaly or masses _____
 Extremities: Symmetric, no deformities _____
 Hips: Negative Barlow/Ortolani, > 60° abduction b/l _____
 Genitourinary: Male: testes descended, _____
 circumcised/uncircumcised _____
Female: normal external genitalia _____
 Neurologic: Moves all extremities symmetrically, _____
 normal tone, (responds to clap) _____

ASSESSMENT:

PLAN:

1. Growth and Developmental Progress
 - Normal for age
 - Concerns _____
2. Immunizations
3. Dental Health
 - Good
 - At risk
 - Caries
4. Screening
 - Hearing Screen: Normal Abnormal
 - Other: (safety, anemia, family, TB, Hep B, Vit D)
 - No risk factors identified
 - Risk factors _____
5. Tobacco exposure
 - Yes No
6. _____

- Discussed recommended schedules, risks and benefits
- DtaP # _____ Prevnar # _____
- HIB # _____ Hep B # _____
- IPV # _____ _____
- Reviewed preventive measures
- Fluoride 0.25 mg/day
- Audiology referral
- HCT
- PPD
- Vit D Supplement
- _____
- Cessation counseling
- Exposure avoidance
- Referral _____

Next visit at 9 Months

- Problem list updated Allergies updated
- Med list updated See dictated note

Provider Signature _____

Date _____

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Preceptor Signature

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