Physicians at Sugar Creek
An Affiliate of MEMORIAL HERMANN

14023 Southwest Freeway
Sugar Land, TX 77479
218.325.4100

6 Month Well Child Exam Form

HEALTH HISTORY

Do you have any questions or concerns about your child's health that you would like to discuss today?

_____

_____

_____

What is your child's health Status? **Good Fair Poor**

Has your child been to the emergency room in the past 12 months: **Yes No**

If yes, list why: _____

Has your child been treated in the hospital in the past 12 months? **Yes No**

If yes, list why: _____

Has your child ever had any reactions to vaccines / immunizations: **Yes No**

Has your child seen a dentist in the last 6 months: **Yes No**

How many times a day does your child brush their teeth? ___ How many times a day do they floss? ___

HOME and FAMILY

Who does the child live with: _____ How many brothers and sisters does he/she have? _____

What do you live in? _____ How many bedrooms are in your home? _____

Does your child share a bedroom: **Yes No** Does anyone in the home smoke? **Yes No**

Is your child's Father Involved in his/her care? **Yes No**

How is your child's relationship with his brothers and/or sisters? **Good Fair Poor N/A, only child**

What type of discipline is used in the home: **Verbal Time-out Spanking Other: _____**

Is there any history of abuse: **Yes No** Is there any history of neglect? **Yes No**

Does anyone in home use drugs: **Yes No** Is there a history of domestic violence? **Yes No**

Has CPS ever been to your home? **Yes No** If yes, is your CPS case still open? **Yes No**

Has your child ever been in foster care? **Yes No** If yes, how many times? _____

Are you feeling stressed? **Yes No**

Do you have pets in the home: **Yes No** If yes, what type? _____

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GENERAL HEALTH

How does your child feed? **Breast feeding** **Pump then bottle feed** **Formula feeding**

What type of formula? _____

How often does he/she feed? Every: **2 hours** **3 hours** **4 hours** **5 hours** **6 hours**

If using formula, how much milk in each bottle? **4 oz** **5 oz** **6 oz** **7 oz** **8 oz**

Does your child drink from: **cup** **bottle only** **cup and bottle**

Does he/she drink juice? **Yes** **No** If yes, how much? _____

Does your child eat: **no solids** **cereal** **vegetables** **fruits** **meats** **junk food**

Does your child have any problems with bowel movements, including constipation or diarrhea? **Yes** **No**

How does your child sleep? **Through the night** **Wakes to feed** **Wakes once** **Wakes twice** **Wakes three times** **Supine (back)** **Prone (stomach)**

How would you describe your child's temperament? **Easy** **Colicky** **Demanding** **Cries when hungry or with needs** **Fussy all the time** **Fussy at night** **Fussy but consolable**

Do you have any concerns about:

- Your child's development? **Yes** **No**
- Your child's behavior? **Yes** **No**

HEARING

Does your child:

Looks to see where sounds come from	**Yes** **No**
Become frightened by an angry voice	**Yes** **No**
Smiles when spoken to	**Yes** **No**
Likes to play with toys or objects that make noise	**Yes** **No**
Babbles (uses a series of sounds)	**Yes** **No**
Makes at least 4 different sounds when using his/her voice	**Yes** **No**
Babbles to people when they speak	**Yes** **No**

VISION

Do you have any concerns about how your child sees	**Yes** **No**
Do you child's eyes appear unusual or seem to cross, drift, or be lazy?	**Yes** **No**

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Do your child's eyelids droop or does one eyelid tend to close? **Yes No**

Have your child's eyes ever been injured? **Yes No**

Check off each task that your child is able to do:

- ☐ Sits briefly
- ☐ Rolls back to front
- ☐ Stands holding on
- ☐ Holds head steady when pulling to sit
- ☐ Reaches for objects
- ☐ Transfers toys from hand to hand
- ☐ Feeds self a cracker
- ☐ Babbles
- ☐ Turns to voice
- ☐ Imitates sounds
- ☐ Feeds self
- ☐ Works to get a toy
- ☐ Shy with strangers

GENERAL SAFETY

Does your child always use a car seat? **Yes No**

Is your home childproofed? **Yes No**

Do you have these things in your home:

Smoke detector **Yes No**

Carbon monoxide detector **Yes No**

Fire extinguisher **Yes No**