PEDIATRIC HEALTH
ASSESSMENT HEALTH
6 MONTHS

CHILD'S NAME: _____ DATE: _____

AGE: _____ ALLERGIES: _____

LIST ALL MEDICAL PROBLEMS: _____

MEDICATIONS: _____

PRESENT CONCERNS/COMPLAINTS: _____

_____

ACCOMPANIED BY: _____ RELATIONSHIP: _____

DAILY LIVING: (FILLED OUT BY PARENT OR GUARDIAN)

DIET: OUNCES PER DAY OF FORMULA_____ (TYPE OF FORMULA)_____ (No. FEEDS/DAY)_____
BREAST FEEDING: TOTAL MINUTES PER FEEDING_____ NUMBER OF FEEDS PER DAY_____
BABYFOOD: circle JAR or FRESH (Check off) CEREAL _____ FRUIT _____ VEGS _____
JUICE (OUNCES/DAY) _____ WATER (OUNCES/DAY) _____
WATER SUPPLY (CIRCLE): CITY WELL BOTTLED IF BOTTLED, NURSERY OR REGULAR? _____

VITAMINS /IRON	☐ NO	☐ YES
ANY SIBLING RIVALRY OR JEALOUSY?	☐ NO	☐ YES
ANY STRESSFUL SITUATIONS IN THE HOUSEHOLD? describe briefly	☐ NO	☐ YES
DO PARENTS OR CAREGIVERS EVER SMOKE?	☐ NO	☐ YES
IS REAR FACING CAR SEAT USED ALL THE TIME?	☐ NO	☐ YES
HAVE SMOKE ALARMS?	☐ NO	☐ YES
ANY EXPOSURE TO ANYONE WITH TB OR WITH HIGH RISK (BORN OR LIVED OUTSIDE THE UNITED STATES, HOMELESS, INCARCERATED, HIV/DRUG USE)?	☐ NO	☐ YES
HOUSE BUILT BEFORE 1980, OR LOCATED NEAR LEAD-RELATED INDUSTRIES?.....	☐ NO	☐ YES
HOUSEHOLD MEMBER/CLOSE CONTACT WITH HIGH LEAD WORK/HOBBY EXPOSURE?..	☐ NO	☐ YES
OTHER LEAD EXPOSURE (I.E.: EATS NON-FOOD ITEMS / PICA; USE ANTIQUE DISHES, ETC; USE PRODUCTS FROM OTHER COUNTRIES SUCH AS HEALTH REMEDIES, ETC.).....	☐ NO	☐ YES

DESCRIBE BOWEL HABITS (No./ DAY) _____ CONSISTENCY/ COLOR _____
NUMBER OF WET DIAPERS PER DAY: _____

DESCRIBE PERSONALITY: _____
SLEEP: HOURS PER DAY? _____ POSITION (SIDE/BACK/BELLY) _____ IN OWN BASINETTE OR CRIB? _____

WHO LIVES IN HOME? _____
DESCRIBE WORK/DAY CARE SITUATION: _____

DEVELOPMENT: (FILLED OUT BY PARENT OR GUARDIAN)

ACTS DIFFERENT AROUND STRANGERS?	☐ NO	☐ YES
ANY CONCERNS ABOUT VISION OR HEARING	☐ NO	☐ YES
GRASPS OBJECTS WITHIN REACH?	☐ NO	☐ YES
HAS GOOD HEAD CONTROL?	☐ NO	☐ YES
MAKES BABBLING SOUNDS (CONSONANTS)?	☐ NO	☐ YES
PUTS WEIGHT ON LEGS?	☐ NO	☐ YES
ROLLS OVER BOTH WAYS?	☐ NO	☐ YES
SHAKES A RATTLE?	☐ NO	☐ YES
SITS ALONE BRIEFLY?	☐ NO	☐ YES
STOPS CRYING IF HE/SHE SEES A BOTTLE OR PARENT?	☐ NO	☐ YES
TRANSFERS TOYS FROM ONE HAND TO ANOTHER HAND?	☐ NO	☐ YES