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