



6 Month Health Maintenance Questionnaire

Patient Name _____

Who accompanied child today?
(name and relationship to child)

Who does child live with?

Any Chronic health problems?

Concerns about the above health problems?

New or recent health concerns?

Feedings:

Breastfeeding:

Is Breastfeeding going well?

Bottle Feeding:

How many ounces per day?

Brand of Formula used?

Any juices or solids started?

If yes, what type?

Any concerns with stooling or urination?

If you do not understand any of these questions, please ask your nurse.

Sleep pattern:

Average number hours of sleep in 24 hours? _____

Frequency of nighttime awakenings? _____

Number of naps? _____

Length of naps? _____

Where does your child sleep? _____

Are there any smokers in the household? _____

Please list current medications: _____

Any allergies to medicine? _____

Does your baby:

Roll over both ways? Yes No

Sit up and brace himself forward? Yes No

Reach for and grasp objects? Yes No

Transfer objects from one hand to the other? Yes No

Turn to the direction of sound? Yes No

Have stranger anxiety? Yes No

Rake with hands to pick up a tiny object? Yes No

If you do not understand any of these questions, please ask your nurse.