Kiddie West Pediatric Center
4766 W. Broad Street
Columbus, OH 43228
614-851-7337

6 Month Questionnaire For Parents

Patient Name	Date of Birth	Age

GENERAL HEALTH AND NUTRITION

1. Has your baby had any injuries since last visit? .... Y N
2. Do you have any concerns about how your baby is eating? .... Y N
3. Check the foods you've given your baby?
   Cereal Fruits Vegetables Meats
4. Has your baby had any reactions to the foods? .... Y N
5. Does your baby only drink well water, bottled water or filtered water? .... Y N
6. Do you have any concerns about how your baby is sleeping? .... Y N
   How many hours does your baby sleep? _____ day _____ night
7. Is your child in daycare? .... Y N
8. Do you talk and read to your baby? .... Y N
9. Do you have any concerns about your baby's vision? .... Y N
10. Do you have any concerns about your baby's hearing? .... Y N

SAFETY

11. Do you always use a rear facing car seat positioned in the back seat? .... Y N
12. Does your baby spend time with anyone that smokes? .... Y N
13. Is there a gun in your home? .... Y N
    If yes is it locked? .... Y N
14. Have you begun to child proof your home? .... Y N
    If yes, check the ones you've done:
    Poisons/medications out of reach Cords Outlet covers
    Cabinet latches Stair gates Irons, curling irons out of reach
    Poison control number (1-800-222-1222)
15. Do you have/use a walker with your child? .... Y N
16. Do you put sun screen on your baby? .... Y N

SOCIAL

17. Are you getting enough rest? .... Y N
18. Do you have concerns about balancing the roles of parent and partner? .... Y N
19. Are there any new stresses or recent changes impacting your family
    (job change, move, divorce, illness)? .... Y N

Please list below any questions or concerns that you would like to talk about today.

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Parent / Guardian Signature and Date	Provider Signature and Date