

PEDIATRIC MEDICAL HISTORY

(Ages 2 months -12 years)

Patient Name:		DOB:	
Source of information: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Family member <input type="checkbox"/> Another person			
MEDICAL HISTORY			
List all Allergies (medications/food/environmental) :			
No significant Past Medical History <input type="checkbox"/> <input type="checkbox"/>			
Please answer all questions that apply to your Child:			
Allergic Rhinitis	<input type="checkbox"/> Yes	Diabetes Mellitus	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> Yes	Eyesight Problems	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes	Fracture	<input type="checkbox"/> Yes
Attention Deficit Disorder (ADD)	<input type="checkbox"/> Yes	Hearing Loss	<input type="checkbox"/> Yes
Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Yes	Preterm Infant	<input type="checkbox"/> Yes
Blood Disorders	<input type="checkbox"/> Yes	Seizure Disorder	<input type="checkbox"/> Yes
Cancer Type:	<input type="checkbox"/> Yes	Does your child receive special education	<input type="checkbox"/> Yes
Cerebral Palsy	<input type="checkbox"/> Yes	Speech Difficulties	<input type="checkbox"/> Yes
Mental Retardation	<input type="checkbox"/> Yes	Gastric Reflux	<input type="checkbox"/> Yes
Is your child presently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, please list what medications, strength and for what condition?			
HOSPITALIZATION/ SURGICAL HISTORY			
Please list below all surgeries and previous hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No - Reason(s) / Date(s)?			
SOCIAL HISTORY			
Please check all that apply to your Child:			
Lives with Parents	<input type="checkbox"/> Yes	Currently in school	<input type="checkbox"/> Yes
Foster Home	<input type="checkbox"/> Yes	Child in Day Care	<input type="checkbox"/> Yes
Group Home	<input type="checkbox"/> Yes	Exposed to cigarette smoke at home	<input type="checkbox"/> Yes
Other: _____	<input type="checkbox"/> Yes	Guns in home	<input type="checkbox"/> Yes
FAMILY HISTORY			
Please check (✓) if any of these apply to any of your Child's family member			
Family History	Mom	Dad	Siblings
Grandparent			
Alcoholism			
Blood Disorders			
Cancer Type:			
Diabetes Mellitus			
Drug Use			
Genetic Disorder			
High Cholesterol			
Hypertension			
Kidney Disease			
Seizure Disorder			
Sickle Cell			
Stroke			
Thyroid Disorders			

Name of Person completing form: _____ Date: _____

5/28/2015

Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	Grade in School?
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)			School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter?
☐ Yes ☐ No

Clinic Use Only:
Nutrition

1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip
7	Are you concerned about your child's weight?	No	Yes	Skip
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip
9	Does your home have a working smoke detector?	Yes	No	Skip
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	Skip
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip

Physical Activity

Safety

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tobacco Exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> Patient Declined the SHA
PCP's Signature		Print Name:			Date:
SHA ANNUAL REVIEW					
PCP's Signature		Print Name:			Date:
PCP's Signature		Print Name:			Date:
PCP's Signature		Print Name:			Date:



Tuberculosis Risk Assessment Screening Questionnaire

Today's Date: _____

Name: _____ **Date of Birth:** _____

*If your child has the appointment today, please fill out the form as it pertains to the child.

<u>Circle any symptoms you are experiencing today:</u>		
Cough	Fever	Loss of Appetite
Coughing Up Blood	Fatigue	Weight Loss
		Night Sweats
1. Have you ever had a <u>positive</u> TB Skin Test or <u>positive</u> TB Blood Test (Quantiferon Level)? (If YES, also answer A-D below). (If NO, skip to Question #2). <div style="background-color: #f0f0f0; padding: 5px; margin-top: 5px;"> Answer only if history of positive TB Test: A. Date of positive test? _____ B. Date of last chest x-ray? _____ Normal: Yes No C. Was a preventive treatment for tuberculosis taken (such as INH)? Yes No D. Preventative treatment dates? _____ </div>	YES	NO
2. Have you had any of the following vaccines: Measles/Mumps/Rubella, Varicella, Zostavax or Nasal flu vaccine in the past 4 weeks?	YES	NO
3. Do you have close contact with someone who has, active Tuberculosis?	YES	NO
4. In the last 5 years have you lived or worked in prison, hospital, nursing home, homeless shelter, foster care or group home?	YES	NO
5. Were you born in Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico?	YES	NO
6. In the last 2 years have you traveled to Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico?	YES	NO
7. Are you currently homeless, a migrant worker, or use street drugs?	YES	NO

I have received information about the TB skin test and have had the opportunity to ask any questions which were answered to my satisfaction. I agree to return in **48-72 hours** to have my TB test read. I understand the risks and benefits of the TB skin test and request the test be administered to me. I understand that if I am symptomatic for TB, or the TB skin test is positive, I will need to follow up with my Primary Care Physician and further treatment may be necessary.

Form Completed By (Signature): _____ **Date:** _____

Print Name: _____

Relationship to Patient: (Self), (Parent), (Guardian), Other): _____

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

What Does Your Child Eat? (Ages Birth – Eight)

Circle the foods your child eats every day or at least 3 times per week: **Baby**

Foods

Breast milk	Formula with Iron	Cereal with Iron		
Pureed Fruit	Pureed Vegetables	Pureed Meat	Eggs	Beans
Juice	Sweetened Beverages	Honey		

Breads, Grains and Cereals

Whole Grain Bread	White Bread	Tortilla	Sweet Bread	
Cereal with Iron	Oatmeal	Bagels	Crackers	Pretzels
Noodle Soup	Pasta	Rice		

Fruits and Vegetables

Apple	Strawberry	Grapes	Pear	Peach	100% Juice
Pineapple	Orange	Banana	Melon	Mango	Cantaloupe
Bell pepper	Chili pepper	Tomato	Potato	Cucumber	Peas
Broccoli	Green Salad	Cabbage	Corn	Green Beans	
Carrots	Sweet Potato	Dark Green Leafy Vegetables			

Milk Products

Whole Milk	2% Milk	1% Lowfat milk	Nonfat Milk
Flavored Milk	Cottage Cheese	Lactose Free Milk	Cheese
Yogurt	Ice Cream		

Other Food Sources of Calcium

Beans	Tofu	Soy Yogurt/Milk	Green leafy vegetables	Calcium
Fortified 100% Juice	Fortified Plant Milk (Almond, Rice)			

Protein Foods

Chicken/Turkey	Meat/Beans Burritos	Ham/Pork	Tacos
Beans/Lentils	Peanuts/Peanut/Nut Butters	Tofu	Beef
Fish/Canned fish	Spaghetti with Meatballs	Eggs	

Other Foods

Hot dog	Hamburger	Pizza	French Fries	Fried Chicken
Chips	Cheese Puffs	Candies	Chocolate	Cookies

Circle if baby/child uses

Fluoride	Iron Drop	Vitamins	
Spoon	Cup	Baby bottle	Toothbrush

Circle if baby/child drinks

Water	Soda	Sugar Sweetened Drinks	Sports Drinks	Juice
-------	------	------------------------	---------------	-------

Circle activities your baby or child does every day

Crawling	Walking	Swinging	Rope jumping
Playing ball	Riding a tricycle/bicycle		

Views TV, video games or computer more than two hours a day

Circle if baby/child receives

CalFresh (Food Stamps)	School Lunch	Head Start	WIC
------------------------	--------------	------------	-----

Child's name: _____ Record #: _____

Age: _____ yrs _____ mos Wt: _____ lbs Ht: _____ in Date: ____/____/____

Adapted from the CHDP Programs of Orange and San Bernardino Counties

Please circle **Yes** or **No**
to answer the following questions:

Birth to 24 months

Does the child less than 1 year
of age eat honey/corn syrup? **Yes No**

0-6 months

Breastfeeding at least 8–12 times
each 24 hours for first 3 months? **Yes No**

Breastfeeding 6-8 times or more
each 24 hours for age 4-6 months? **Yes No**

Feeding formula with iron
at least 20 ounces a day? **Yes No**

6 to 9 months

Eats baby cereal with iron? **Yes No**

Eats pureed fruits and **Yes No**

vegetables? Eats pureed or
cooked egg yolk, beans, tofu? **Yes No**

Drinks or sips from a cup? **Yes No**

9 to 12 months

Eats mashed/chopped foods? **Yes No**

Eats foods with fingers? **Yes No**

1 to 2 years

Drinks 16 ounces whole milk a day? **Yes No**

Eats a variety of different foods? **Yes No**

Feeds himself (or herself)? **Yes No**

Joins family meal and snack times? **Yes No**

Drinks soda or other sweet drinks? **Yes No**

Other

Does the child have food
allergies or intolerances? **Yes No**

Please list: _____

Does the child play with or eat
dirt, plaster, clay or paint chips? **Yes No**

Does the child 3 years or younger
eat grapes, nuts, seeds, popcorn,
hot dogs and/or hard candy? **Yes No**



OFFICE USE ONLY

Referred for
Identified nutrition problem? **Yes No**

If yes, where: _____

Provider initials: _____