PEDIATRIC MEDICAL HISTORY

(Ages 2 months -12 years)

Patient Name: **DOB:**

Source of information: [ ] Mother [ ] Father [ ] Family member [ ] Another person

MEDICAL HISTORY

List all Allergies (medications/food/environmental) :

No significant Past Medical History [ ]

Please answer all questions that apply to your Child:

Allergic Rhinitis	□ Yes	Diabetes Mellitus	□ Yes
Anemia	□ Yes	Eyesight Problems	□ Yes
Asthma	□ Yes	Fracture	□ Yes
Attention Deficit Disorder (ADD)	□ Yes	Hearing Loss	□ Yes
Attention Deficit Hyperactivity Disorder (ADHD)	□ Yes	Preterm Infant	□ Yes
Blood Disorders	□ Yes	Seizure Disorder	□ Yes
Cancer Type:	□ Yes	Does your child receive special education	□ Yes
Cerebral Palsy	□ Yes	Speech Difficulties	□ Yes
Mental Retardation	□ Yes	Gastric Reflux	□ Yes

Is your child presently taking medication? □ Yes □ No - If yes, please list what medications, strength and for what condition?

HOSPITALIZATION/ SURGICAL HISTORY

Please list below all surgeries and previous hospitalizations? □ Yes □ No - Reason(s) / Date(s)?

SOCIAL HISTORY

Please check all that apply to your Child:

Lives with Parents	□ Yes	Currently in school	□ Yes
Foster Home	□ Yes	Child in Day Care	□ Yes
Group Home	□ Yes	Exposed to cigarette smoke at home	□ Yes
Other: _____	□ Yes	Guns in home	□ 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

0 – 6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ 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:
1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition
2	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
3	Does your baby watch any TV?	No	Yes	Skip	
4	Does your home have a working smoke detector?	Yes	No	Skip	Safety
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

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.

Circle any symptoms you are experiencing today:

Cough Fever Loss of Appetite Coughing Up Blood Fatigue Weight Loss Night Sweats

1. Have you ever had a **positive** TB Skin Test or **positive** TB Blood Test (Quantiferon Level)? **(If YES, also answer A-D below). (If NO, skip to Question #2).** _____ **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? _____	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?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
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?	☐	☐	☐
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?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☐	☐
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?	☐	☐	☐
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?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

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.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf ▪ Item #P4060 (9/17)

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/MilkGreen 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 vegetables? **Yes No**
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: _____