

INFANCY, CHILDHOOD, ADOLESCENCE, HISTORY

Date: _____

1

Child's Name _____
 Date of Birth _____ [] M [] F
 Social Security No. _____
 Child Lives With _____
 Address _____
 Telephone No. _____

Previously Seen/Treated By _____
 Address _____
 Child's School _____
 Address _____

2. CHILD'S BIRTH HISTORY

During your pregnancy with this child did you:

1. Have high blood pressure? [] YES [] NO
2. Have diabetes or sugar in your urine? [] YES [] NO
3. Have albumin or protein in your urine? [] YES [] NO
4. Have a urinary infection? [] YES [] NO
5. Have German (3day) Measles? [] YES [] NO
6. Take any medicines? [] YES [] NO
7. Smoke cigarettes? [] YES [] NO
8. Get treatment for gonorrhea or syphilis? [] YES [] NO
9. Drink alcohol? [] YES [] NO
10. Other drugs? [] YES [] NO
11. How long was your pregnancy? _____ months
12. How early did you start seeing the doctor? _____ month
13. Have this child early (premature)? [] YES [] NO
14. Have more than one baby delivered? [] YES [] NO
15. Have a difficult labor? [] YES [] NO
 - Was it breech (bottom first) delivery? [] YES [] NO
 - Was it a Cesarean delivery? [] YES [] NO

3. CHILD'S PAST/PRESENT MEDICAL NUTRITIONAL HISTORY

1. Did your baby breathe/cry immediately at birth? [] YES [] NO
2. Was the baby jaundiced at birth? [] YES [] NO
3. Did the baby have an RH problem? [] YES [] NO
 Receive blood? [] YES [] NO
4. At birth, did the baby appear normal? [] YES [] NO
5. Was Sickle Cell testing done at birth? [] YES [] NO
6. Was PKU testing done at birth? [] YES [] NO
7. During baby's FIRST year, did you breast feed? [] YES [] NO
8. During baby's FIRST year, did you formula feed? [] YES [] NO
 How long? _____
9. If feeding problems, explain: _____
10. Weaning from breast completed at: _____ *Child's age*
11. Whole milk started at: _____ *Age*
 Problems/Allergies? _____
12. Solid food started at: _____ *Age*
 Problems/Allergies? _____
13. Any weight loss/gain problems [] YES [] NO

4. IMPORTANT MEDICAL INFORMATION

ILLNESS/ACCIDENT/SURGERY	COMPLICATIONS/SEVERITY	ALLERGIC REACTIONS TO DRUGS, FOOD?	AGE OF CHILD
1			
2			
3			
4			
5			

Turn over and complete

KRMF FAMILY PRACTICE RESIDENT CLINIC INFANCY, CHILDHOOD, ADOLESCENCE, HISTORY

5. IMMUNIZATION INFORMATION

NAME	REACTION	DATES (if known)			REACTION
1 DPT or DTaP					
2 Td					
3 HIB					
4 Polio (IPV or OPV)					
5 MMR					
6 Hep B					
7 Varicella					
8 T.B. Test (optional-high risk)					
9 Other					

6. SOCIAL/DEVELOPMENTAL HISTORY

- | | |
|--|--|
| <p>1. Mother's age? _____ Father's age? _____</p> <p>2. Child has how many sisters? _____ brothers? _____</p> <p>3. Child is _____ in family?</p> <p>4. Other children's ages ____/____/____/____/____/____</p> <p>5. Who spends more time caring for child? _____</p> <p>6. Does child go to day care, babysitter or preschool on regular basis? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>7. Child sat up at: _____ Age</p> <p>8. Child crawled at: _____ Age</p> <p>9. Child walked at: _____ Age</p> <p>10. Child started talking at: _____ Age</p> <p>11. Child's school progress is age appropriate? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|--|--|

7. FAMILY HISTORY

Has any blood relative of your child had or been treated for:

- | | |
|--|--|
| Allergies <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Trouble <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Blood disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes (sugar in urine) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cancer <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis (T.B.) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Lung disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Mental illness <input type="checkbox"/> YES <input type="checkbox"/> NO |

8. CONCERNS/ PROBLEMS

Does your baby/child have any ongoing problem(s) that concern you? If yes, put an X in box(es).

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Eats too little | <input type="checkbox"/> Eats too much | <input type="checkbox"/> Speaks unclearly | <input type="checkbox"/> Always has runny nose and/or cough |
| <input type="checkbox"/> Cries a lot | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Doesn't always respond to noise or spoken word | <input type="checkbox"/> Sees poorly |
| <input type="checkbox"/> Won't sleep | <input type="checkbox"/> Frequently constipated | <input type="checkbox"/> Seem small for age | <input type="checkbox"/> Wets bed <input type="checkbox"/> depression <input type="checkbox"/> Sexual activity |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Transportation available for doctor appointments | <input type="checkbox"/> Substance abuse |

Are there any other problems? Please write them down: _____

SIGNATURE _____ REVIEWED BY: _____