HISTORY

It is very important that you complete every question

Child's Name: _____ **SSN:** _____

*Current Medicines: Over the counter and prescription medicine _____

_____

***Please check below any service your child is currently receiving:**

____Development (motor skills/learning) ____Speech/Language ____Vision (child wears glasses)

Diet, Sleep & Elimination

WIC	☐ No	☐ Yes
Does your child eat Breakfast?	☐ No	☐ Yes
Does your child eat fruits and vegetables?	☐ No	☐ Yes
Does your child drink Low fat milk?	☐ No	☐ Yes
Does your child eat Supper with family?	☐ No	☐ Yes
Does your child eat a lot of fried or fatty foods?	☐ No	☐ Yes

How many hours does your child sleep at night? ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13

Your child's urine output is: ☐ Normal ☐Increased ☐Decreased

Your child's bowel movements are: ☐ Normal ☐Diarrhea #___days ☐ Hard #____ days

Does your child usually drink: ☐City Water ☐Well Water ☐ Bottled Water

Is your child's appetite: ☐Good ☐Average ☐ Picky

Pregnancy (of the Mother) and Newborn History

Was this child born early? ☐No ☐Yes

Did you or the baby have any difficulties and/or problems during pregnancy or at birth? ☐No ☐Yes

Explain _____

Please respond to each item below

Child's Health History -Has your child ever had any of the following…?

	No	Yes		No	Yes	
Anemia	☐	☐	Heart trouble	☐	☐	Type_____
Asthma	☐	☐	Heart murmur	☐	☐	
Behavioral Problems	☐	☐	PE tubes in ears	☐	☐	
ADHD/ADD	☐	☐	Ear infections	☐	☐	
Thyroid problems	☐	☐	Bleeding problems	☐	☐	Type_____
Eczema	☐	☐	Jaundice/Liver trouble	☐	☐	
Diabetes/sugar	☐	☐	Cancer	☐	☐	Type_____
HIV/AIDS	☐	☐	Mumps	☐	☐	
TB	☐	☐	Sickle cell	☐	☐	Type_____
Seizures	☐	☐	Chicken Pox	☐	☐	
Acne	☐	☐	(Girls) Started period	☐	☐	Month____ Year____
Other	☐	☐				

Explain and/or any additional information _____

Are his/her shots up to date? ☐No ☐Yes ☐Unknown

Has your child been in the hospital or had surgery? ☐No ☐Yes (Explain and give dates):_____

_____

DOES YOUR CHILD HAVE ANY ALLERGIES? MEDICINES, FOOD, OR ENVIRONMENTAL:
☐No ☐Yes LIST _____

Developmental History
Did your child have any delay in ☐sitting ☐ walking ☐talking? ☐No ☐Yes (If yes, please explain):

_____

Have you noticed any difference in the way your child has developed from other children his/her age?
☐ No ☐Yes (If yes, please explain):_____

_____

Family History
(Mark: M=Mother, F-Father, S=Sister, B=Brother, GM=Grandmother, GF=Grandfather, N=None)

_____Birth defects: Type _____	_____Chest pain	_____Mental illness
_____High blood pressure	_____Liver disease	_____Inherited disease: Type_____
_____Heart problems: Type _____	_____TB	_____Diabetes/Sugar
_____Asthma/Lung disease	_____ Sickle Cell	_____Other _____
_____Cancer: Type_____	_____ Stroke	

Social/Socioeconomic History

Number of children in the home _____
Does anyone smoke in the home? ☐No ☐Yes
Is there a working smoke alarm? ☐No ☐Yes
Does the child wear a seat belt? ☐No ☐Yes
Has the child repeated any grades? ☐No ☐Yes If yes which grade _____
Are you a ☐Single parent ☐ Both parents in home ☐ Both parents involved in child's care
Does your child have any problems with school? ☐No ☐Yes If yes, explain below

OFFICE USE ONLY

NURSE SIGNATURE:_____DATE: _____

PEDIATRIC SYMPTOM CHECKLIST 17 (PSC-17)

Child's name: _____

***Required information**

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you can help your child get the best care possible by answering the following questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	Never	Sometimes	Often
1. Fidgety, unable to sit still	0	1	2
2. Feels sad, unhappy	0	1	2
3. Daydreams too much	0	1	2
4. Refuses to share	0	1	2
5. Does not understand other people's feelings	0	1	2
6. Feels hopeless	0	1	2
7. Has trouble concentrating	0	1	2
8. Fights with other children	0	1	2
9. Is down on him or herself	0	1	2
10. Blames others for his or her troubles	0	1	2
11. Seems to be having less fun	0	1	2
12. Does not listen to rules	0	1	2
13. Acts as if driven by a motor	0	1	2
14. Teases others	0	1	2
15. Worries a lot	0	1	2
16. Takes things that do not belong to him/her	0	1	2
17. Distracted easily	0	1	2
TOTALS:			
Comments:			

RISK ASSESSMENT QUESTIONNAIRE

Child's Name: _____

Tuberculosis. - Answer for children all ages	No	Yes	Unsure
1. Has your child been in close contact with a person with infectious tuberculosis?			
2. Does your child live in an established "high risk for tuberculosis" community or area?			
3. Does your child have HIV infection or considered at risk for HIV infection?			
4. Is your child in contact with the following individuals: HIV infected, homeless, nursing home residents, institutionalized or incarcerated adolescents and/or adults, illicit drug users, or migrant farm workers?			
5. Does your child have a depressed immune system, either because of disease or treatment of disease?			
6. Is your child foreign born (especially if born in Asia, Africa or Latin America), a refugee, or an immigrant?			
7. Has your child had a positive TB skin test before?			

Cholesterol . - Answer for children all ages	No	Yes	Unsure
8. Does child have risk factors for future coronary disease such as physical inactivity, obesity, or Diabetes Mellitus?			
9. Is there a family history (parents and/or grandparents) of coronary or peripheral vascular disease below age 55?			
10. Is there a family history (parents and/or grandparents) of elevated blood cholesterol?			

Lead. - Answer for children 12 months up to 6 years of age ONLY	No	Yes	Unsure
11. Does your child live in or regularly visit a house/apartment built before 1950? (This could include a daycare center, home of a baby sitter, or a relative)			
12. Does your child have a sibling or a playmate that has, or did have lead poisoning?			
13. Does your child live near or visit with someone who lives or works near a lead smelter, battery recycling plant industry that could release lead, or has a hobby which uses lead such as welding, construction, or pottery making?			
14. Have you ever been told that your child has low iron?			
15. Does your family use pottery ware or lead crystal for cooking, eating, or drinking?			
16. Has your child ever eaten paint chips, crayons, or soil/dirt?			
17. Is child given any home or folk remedies that my contain lead (may include moonshine, Azarcon, Greta, Payloooah)?			
18. Does your home's plumbing have lead pipes or copper pipes with lead solder joints?			