

**MERCY GENERAL HEALTH PARTNERS PRIMARY CARE NETWORK: NEW CHILD VISIT**

PARENTS: Please complete this form as well as you can. Thank you. Today's Date: \_\_\_/\_\_\_/\_\_\_

**CHILD's NAME:** \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Sex: M F

Birth Weight: \_\_\_lbs \_\_\_oz

Parents/Guardians' Names: \_\_\_\_\_ Person with child: \_\_\_\_\_

**GENERAL:**

Current health problems:

Do you have any concerns about your child's behavior or discipline?

Do you ever feel frustrated or think about injuring your child?

Who helps care for your child?

Has your child had any reactions to immunizations?

Medications:

Allergies to medications:

**PAST MEDICAL HISTORY:**

Chronic Illnesses:

Hospitalizations:

Surgeries:

**BIRTH HISTORY:**

The infant was delivered by: \_\_\_ Spontaneous \_\_\_ Induced vaginal delivery  
\_\_\_ C-section at \_\_\_ weeks gestation.

At delivery mother was \_\_\_ years old and had been pregnant \_\_\_ times, delivered \_\_\_ children

Birth weight was \_\_\_ lbs. \_\_\_ ounces, length \_\_\_ inches.

Apgar scores were \_\_\_ and \_\_\_

Was the initial physical examination normal? Yes \_\_\_\_\_ No \_\_\_\_\_

The hospital course was uncomplicated \_\_\_\_\_ complicated \_\_\_\_\_

Did the infant receive Hepatitis B vaccine in hospital: Yes \_\_\_ No \_\_\_

The infant was discharged to home on day \_\_\_\_\_

During the pregnancy, the mother used:

Medications: \_\_\_\_\_

Alcohol: Yes \_\_\_ No \_\_\_

Tobacco: Yes \_\_\_ No \_\_\_

Cocaine: Yes \_\_\_ No \_\_\_

Other drugs: Yes \_\_\_ No \_\_\_

Was the mother exposed to:

X-rays: Yes \_\_\_ No \_\_\_

Other teratogens: Yes \_\_\_ No \_\_\_

Maternal infections: Yes \_\_\_ No \_\_\_

Other illness: Yes \_\_\_ No \_\_\_

**FAMILY HISTORY**

Significant for:

Allergies: Yes \_\_\_ No \_\_\_

Congenital anomalies (Birth Defects): Yes \_\_\_ No \_\_\_

Heart disease, strokes: Yes \_\_\_ No \_\_\_

Kidney disease: Yes \_\_\_ No \_\_\_

Endocrine (diabetes/thyroid) disease: Yes \_\_\_ No \_\_\_

Cancer: Yes \_\_\_ No \_\_\_

Seizures: Yes \_\_\_ No \_\_\_

Tuberculosis: Yes \_\_\_ No \_\_\_

Other: \_\_\_\_\_

**SOCIAL HISTORY**

Child lives with \_\_\_\_\_

Does anyone smoke in your home? \_\_\_\_\_

Do you have any pets: \_\_\_\_\_ Do you have guns in the home? \_\_\_\_\_

School performance? \_\_\_\_\_ Grade? \_\_\_\_\_ Name of School? \_\_\_\_\_

**NUTRITION:**

Milk per day \_\_\_\_\_ ounces

Water per day \_\_\_\_\_ ounces

Juice per day \_\_\_\_\_ ounces

Pop per day \_\_\_\_\_ ounces

Diet habits?

Supplements:

Vitamins: yes no

Iron: yes no

Fluoride: yes no

**REVIEW OF SYSTEMS:**

Please check if the child has had any of the following symptoms or diseases:

Vision: \_\_\_\_\_

Hearing: \_\_\_\_\_

Ear: \_\_\_\_\_

Sinus: \_\_\_\_\_

Speech: \_\_\_\_\_

Skin: \_\_\_\_\_

Bowel/stomach: \_\_\_\_\_

Lung/breathing: \_\_\_\_\_

Urination/bedwetting: \_\_\_\_\_

Eating/appetite: \_\_\_\_\_

Infections: \_\_\_\_\_

Jaundice/liver: \_\_\_\_\_

Seizures: \_\_\_\_\_

Anemia/Sickle Cell: \_\_\_\_\_

Heart Murmur: \_\_\_\_\_

Joint/muscles: \_\_\_\_\_

Chicken Pox: \_\_\_\_\_

Measles: \_\_\_\_\_

Mumps: \_\_\_\_\_

Pneumonia: \_\_\_\_\_

Weight loss/gain: \_\_\_\_\_

Behavioral Problems: \_\_\_\_\_

Bleeding: \_\_\_\_\_

Other Problems: \_\_\_\_\_

**DEVELOPMENT:**

What new things is your child doing? «\*»

How old was your child when s/he walking? «DEL»

How old was your child when s/he spoke first word? «DEL»  
How old was your child when s/he was fully potty trained? «DEL»

### **TB/LEAD QUESTIONNAIRE**

Does your child:

Live in (or lived in) or regularly visit a house built before 1950 with chipping or peeling paint? Yes \_\_\_ No \_\_\_

*This could include a day care, preschool, home of a babysitter or relative, etc.*

Live in (or lived in) or regularly visit a house built before 1978 with recent (within the past 6 months), ongoing or planned renovation or remodeling? Yes \_\_\_ No \_\_\_

Have or had a brother or sister, housemate or playmate with lead poisoning? Yes \_\_\_ No \_\_\_

Live (or ever lived) near a busy street or highway? Yes \_\_\_ No \_\_\_

Eat, drink or use any home or folk remedies which may contain lead? Yes \_\_\_ No \_\_\_

Does your home's plumbing have lead pipes or copper pipes with lead solder joints? Yes \_\_\_ No \_\_\_

\_\_\_

Has your child:

Ever had a positive skin test for TB (tuberculosis)? Yes \_\_\_ No \_\_\_

Had an MMR (measles, mumps, rubella) vaccination in the last 4 weeks? Yes \_\_\_ No \_\_\_

Lived (or lived with someone) who has been outside of the continental U.S. within the last 5 years? (yes if your child is foreign-born) Yes \_\_\_ No \_\_\_

Lived with (or had recent contact with) someone with tuberculosis? Yes \_\_\_ No \_\_\_

Lived with (or had recent contact with) someone with HIV-positive or AIDS? Yes \_\_\_ No \_\_\_

Lived with (or had recent contact with) someone living in prison, jail, nursing home, long-term care facility or homeless shelter? Yes \_\_\_ No \_\_\_