

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 problems: _____

How are you (parents) doing? _____

Who babysits? _____

Do you ever feel frustrated or that you might injure your child? _____

Medications: _____

Allergies: _____

PAST MEDICAL 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 within 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 ___

Section 1.01 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 ___

FAMILY HISTORY (continued)

Cancer: Yes ___ No ___

Seizures: Yes ___ No ___

Tuberculosis: Yes ___ No ___

Other: _____

SOCIAL HISTORY

Infant lives with _____

Does anyone smoke in your home? _____

Do you have any pets: _____ Do you have guns in the home? _____

NUTRITION:

Formula Type: _____ Ounces per feeding _____ Frequency: every _____ hours

Nursing: How long per feeding: _____ minutes Frequency: every _____ hours

Water per day: _____ ounces per day

Wet diapers per day _____ Stools per day _____ Spits up: Yes ___ No ___

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: _____ | Seizures: _____ |
| Hearing: _____ | Anemia/Sickle Cell: _____ |
| Ear: _____ | Heart Murmur: _____ |
| Sinus: _____ | Joint/muscles: _____ |
| Speech: _____ | Chicken Pox: _____ |
| Skin: _____ | Measles: _____ |
| Bowel/stomach: _____ | Mumps: _____ |
| Lung/breathing: _____ | Pneumonia: _____ |
| Urination/bedwetting: _____ | Weight loss/gain: _____ |
| Eating/appetite: _____ | Behavioral Problems: _____ |
| Infections: _____ | Bleeding: _____ |
| Jaundice/liver: _____ | Other Problems: _____ |

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 ___