Mankato Clinic

Health History 6 – 7 years old

Interpreter Present: ___ Yes ___ No
Name: _____
Language: _____

Brought into Clinic by: _____

List any questions or concerns you have about your child:

_____

_____

_____

PAST HEALTH HISTORY

Has your child ever had any of the following? If yes, please list what they had and when it occurred:

	Yes	No
1. Allergic reaction to:		
▪ Medication _____	□	□
▪ Foods_____	□	□
▪ Insect bites_____	□	□
▪ Immunizations (shots)_____	□	□
▪ Animals_____	□	□
2. Hospitalizations? _____	□	□
3. Surgery?_____	□	□
4. Serious injuries or accidents?_____	□	□
5. Broken bones or stitches?_____	□	□
6. Fainting episodes?_____	□	□

Has your child required any special tests? □Yes □No
Please explain _____
_____
_____

Please check (√) if your child has ever had any of the following:

□ ADD / ADHD
□ Anxiety
□ Autism / PPD
□ Anemia (low-iron in blood)
□ Asthma
□ Bladder/Kidney infection
□ Chickenpox
□ Depression
□ Diabetes
□ Ear infections
□ Frequent respiratory infections
□ Hay fever / Allergies
□ Meningitis
□ Pneumonia
□ Seizures
□ Sinus Infections
□ Strep infections/ Scarlet Fever
□ None

Please list any information about your child that you feel we should know: _____
_____
_____
_____
_____
_____

CURRENT HEALTH HISTORY

- Please list any medications taken on a regular basis, including over-the-counter and herbal preparations:
  _____
  _____
- Has your child had all of their immunizations (shots)? □Yes □No □ I don't know

A. Eating / Nutrition

1. How does your child eat? □ Excellent □ Good □ Fair □ Poor
2. List any concerns you have about your child's eating:
   _____
   _____
   _____
3. Does your child take vitamins? □Yes □No
4. Rate how your child eats these foods:

	Good	Fair	Poor
▪ Dairy/Milk	□	□	□
▪ Fruit	□	□	□
▪ Vegetables	□	□	□
▪ Meats	□	□	□
▪ Bread/Cereal/Pasta	□	□	□

5. How many times per day does your child eat sweets, chips, junk foods, etc? _____
6. How many cans of pop does your child drink in:
   - a day? _____
   - a week? _____

B. Elimination

1. How often does your child have a stool?
   _____
   - Any constipation? □Yes □No
   - Diarrhea? □Yes □No
2. Any concern with urination? □Yes □No
   - Pain when urinating? □Yes □No
   - Urinating very often in small amounts? □Yes □No
   - Bed-wetting? □Yes □No
   - Blood in urine? □Yes □No

C. Sleep

1. Any concerns with sleeping? □Yes □No
   List _____
2. What time does your child:
   - Go to sleep at night? _____
   - Get up in the morning? _____
3. Any difficulty falling asleep at night? □Yes □No
4. Does your child have nightmares? □Yes □No
5. Does your child snore? □Yes □No

D. Dental

1. Does your child brush his/her teeth? □Yes □No
   - What time of the day? _____
2. Does your child floss his/her teeth? □Yes □No
   - What time of the day? _____
3. Date of last dental visit _____
4. List any dental concerns:_____
   _____
5. Type of drinking water? □City □Well
   - **If well water,** does your child take fluoride? □Yes □No

E. Safety

1. Does your child use a car seat or booster seat? □Yes □No
2. Does your child use a seat belt? □Yes □No
3. Does your child wear a bike helmet? □Yes □No
4. Does your child wear wrist guards when rollerblading? □Yes □No □Doesn't rollerblade

F. Activity / Hobbies

1. What does your child do for exercise? _____
   _____
   How often? _____
3. How much TV does your child watch per day?
   □ 0-1 hr □ 1-2 hrs □ 2-5 hrs □ 5 or more hrs
4. Does your child have any hobbies? □Yes □No
   If yes, what are they? _____
   _____
   _____
   _____

G. Development

1. Do you have any concerns about your child's:

	Yes	No
▪ vision?	□	□
▪ hearing?	□	□
▪ development?	□	□
▪ school performance (reading/math at grade level)?	□	□
▪ ability to form/maintain peer relationships?	□	□
▪ family relationships?	□	□
▪ social skills?	□	□
▪ communication skills?	□	□

2. Do you have any concerns about your child's mental health? If yes, what? □Yes □No
   □ sad/depressed □ anxiety/worrier
   □ angry □ other _____

H. Behavior

1. **Check (√) if you have any concerns about the following behaviors noted in your child:**
   □ Bad temper
   □ Cries easily and often
   □ Nail biting
   □ Often irritable/ disobedient
   □ Overly cautious, shy, fearful
   □ Problems with discipline
   □ Speech problems
   □ Tendency to break or destroy things
   □ Thumb sucking
   □ None noted / No concerns
2. List any concerns you have about your child's behavior, discipline or parenting: _____
   _____
   _____
   _____
   _____

I. School / Social

1. Does your child get along well with other children? □Yes □No
2. Does your child like school? □Yes □No
3. Has your child required any special classes or help in school? □Yes □No
4. Do you have any concerns about your child's work in school? □Yes □No
5. Favorite subject _____
   Least Favorite subject _____
6. What sports activities is your child involved in?
   _____
   _____

J. Family

Please answer these questions pertaining to your home:

1. Who lives there? _____
   _____
   _____
2. Any problems/major stressors? □Yes □No
   - If yes, please explain: _____
     _____
3. Do you have any pets? □Yes □No
4. Anyone smoke? □Yes □No
   - If yes, who? _____
5. Any guns? □Yes □No
6. Anyone have a problem with alcohol? □Yes □No
   - If yes, who? _____
7. Anyone have a problem with drugs? □Yes □No
   - If yes, who? _____
8. Do you have any concerns about safety at your house? □Yes □No
   - If yes, please explain: _____
     _____
     _____
9. Is there violence in any of your family relationships? □Yes □No
   - If yes, please explain: _____
     _____
     _____
     _____
10. How does your child get along with:
    - Parents? □ Excellent □ Good □ Fair □ Poor
    - Brothers/Sisters? □ Excellent □ Good □ Fair □ Poor

K. Lead

Please answer these questions pertaining to lead exposure:

1. Does the child live in or frequently visit houses built before 1950? □Yes □No
2. Does the parent/caregiver have contact with lead in their jobs? □Yes □No
3. Do you live near roads with heavy traffic or near lead smelters or processing plants? □Yes □No
4. Has another child in your house or any of your child's playmates had lead poisoning? □Yes □No
5. Do you use any folk medicines with your child? □Yes □No
6. Do you have any lead paint or pipes in your home? □Yes □No
7. Has your house been repainted within the last 20 years? □Yes □No

L. Tuberculosis (T.B.)

1. Has your child ever been treated for tuberculosis? □Yes □No
2. Has your child ever been around anyone with tuberculosis? □Yes □No

M. Family History

□ Child adopted, family history is unknown.
□ One or more parent is adopted, family history is unknown.

1. Are the child's parents in good health? □Yes □No
2. Check (√) any diseases that the child's **parents, grandparents, brothers, sisters, aunts or uncles** have had and indicate which family member in space provided:

□ Alcohol or drug problems _____
□ Allergies/Hayfever _____
□ Asthma _____
□ Birth defects _____
□ Bleeding disorders _____
□ Cancer _____
□ Diabetes _____
□ Ear infections _____
□ Eczema/Psoriasis _____
□ Epilepsy/Seizures _____
□ Hearing problems/Deafness _____
□ Heart murmur _____
□ Heart problems/Heart attacks _____
□ High blood pressure _____
□ High cholesterol _____
□ Kidney problems/Bladder infections _____
□ Learning problems _____
- ADD / ADHD _____
- Intellectual Disability_____
- Reading problems_____

□ Mental illness/Depression _____
□ Migraine Headaches _____
□ Obesity (overweight) _____
□ Scoliosis (curvature of the spine) _____
□ Sinus problems _____
□ Stroke _____ Please chec
□ Sudden deaths during exercise _____
□ Thyroid problems _____
□ Tuberculosis _____
□ Ulcers _____
□ Vision problems:
- Crossed eyes _____
- Glaucoma _____
- Cataracts _____
- Lazy Eye_____

N. Review of Systems

Check (√) if your child has any of the following:

□ Blurry vision / Difficulty seeing
□ Bruises easily
□ Clumsy/awkward
□ Crossed eyes
□ Difficulty Breathing
□ Difficulty Hearing
□ Difficulty swallowing
□ Dizziness
□ Dry skin
□ Falls down more than other children
□ Frequent cough
□ Frequent ear infections
□ Frequent runny / stuffy nose
□ None
□ Frequent sore throat
□ Headaches
□ Heart murmur
□ Hoarse sounding voice
□ Mattery eyes
□ Muscle/joint pain
□ Poor activity level/ easily tired
□ Rashes
□ Red eyes
□ Stomach cramps
□ Vomiting
□ Walks funny - toes in or out
□ Other _____

O. Active Community Services

Please check (√) if your child participates in any of the following:

□ WIC
□ Public Health
□ MFIP
□ ECFE
□ Spiritual
□ Other _____

Reviewed by _____
(Medical Provider's signature)