Mankato Clinic

Health History 0-1 month

Interpreter Present: ____ Yes ____ No
Name: ______________________________
Language: ______________________________

Brought into Clinic by: ______________________
List any questions or concerns you have about your child:
____
____
____

PAST HEALTH HISTORY

***If you have already completed this form for a first week visit, please skip to current Health History on next page.**

A. Pregnancy and birth

1. Did mother have any illness/ problems during pregnancy with this child? □Yes □No
2. Was this child born prematurely? □Yes □No
3. Mother's weight gain? ________
4. During the pregnancy, did mother use:
   - Cigarettes? □Yes □No
     How much? ______________________
   - Alcohol? □Yes □No
     How much? ______________________
   - Street drugs? □Yes □No
     How much?______________________
5. Type of birth? □Vaginal □Cesearean
6. Any problems during labor or delivery? If yes, please explain: □Yes □No ____________
____
____
____
7. Baby's birthweight ______________________
8. Did baby/mother have any problems when in hospital? If yes, please explain: □Yes □No ______________________
____
____
9. Did your child require any special tests? If yes, please explain: □Yes □No ______________
____
____

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

	Yes	No
10. Allergic reaction to:		
▪ Medications______________________	□	□
▪ Immunizations (shots)______________	□	□
11. Hospitalizations? ______________________	□	□
12. Surgery?______________________	□	□
13. Serious injuries or accidents?____________	□	□

B. Family History

□ Child is Adopted—Family history unknown
□ Parent is Adopted—Family history unknown

1. Are parents both in good health? □Yes □No
2. **Check** (√) any health conditions your **child's parents, grandparents, brothers, sisters, aunts, or uncles** have had and indicate which family member by writing behind the condition.

□ 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______________

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Family History (continued)

☐ Learning problems
- ADD/ADHD ______________________
- Reading problems ________________

☐ Mental illness/Depression _______________
☐ Migraines ______________________________
☐ Obesity (overweight) ____________________
☐ Scoliosis (curvature of the spine)___________
☐ Sinus problems ________________________
☐ Stroke _________________________________
☐ Sudden deaths during exercise ____________
☐ Thyroid problems _______________________
☐ Tuberculosis ___________________________
☐ Ulcers _________________________________
☐ Vision problems
- crossed eyes ______________________
- glaucoma ________________________
- cataracts _________________________
- lazy eye __________________________

List any other illnesses that run in the family: ________
____
____
____

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*CURRENT HEALTH HISTORY

A. Feeding/Nutrition

1. How does your child eat? ☐ Excellent ☐Good ☐ Fair ☐ Poor
2. List any concerns you have about your child's eating: ______________________________
____
____
____
3. How is your child fed?
   - **Breast –** how often? ________________
     Any problems? ________________________
     ____
     Taking vitamins? ☐Yes ☐No
   - **Bottle –** type of formula/milk ____________
     How much? ___________________________
     How often?___________________________
4. Does your child spit up much? ☐Yes ☐No

B. Elimination

1. How often does your child have a stool (messy pants)? ______________________________
2. Do you have any concerns with voiding (wet pants)? ☐Yes ☐No If yes, please explain: ________
____
____
____

C. Sleep

1. Any concerns with sleeping? ☐Yes ☐No
2. How does your child go to sleep?
   ☐ rocked
   ☐ laid in bed awake/falls asleep on own
   ☐ falls asleep while being fed
   ☐ falls asleep with bottle in crib
   ☐ Other ______________________________

D. Safety

1. Does your child have a car seat? ☐Yes ☐No
2. What type? ☐ Infant ☐ Convertible
3. Which direction does it face? ☐ Rear ☐ Forward

E. Temperament

- How would you describe your baby's temperament?
____
____
____
____

F. Development

1. Do you have any concerns about your child's vision? ☐Yes ☐No
2. Does you child move his/her arms and legs well? ☐Yes ☐No
3. Does your baby respond to your voice? ☐Yes ☐No
4. When you hold your baby in the upright position, can he/she support their head for more than a moment? ☐Yes ☐No

5. Do you have any concerns about your child's development? ☐Yes ☐No
   What are they? ______________________________
   ____
6. Do you feel your child is doing what he/she should be doing for his/her age? ☐Yes ☐No

- **Please answer the following questions pertaining to your child's development.**

Personal/Social/Cognitive	Y	N
• Makes eye contact		
• Responds to sight		
• Alert: interested in sights and sounds		
Fine motor/adaptive		
• Follows moving objects with eyes		
Language		
• Makes small throaty sounds/coos		
• Responds to sound		
Gross Motor		
• Lifts head and chest when lying on abdomen		

G. Family

*** If your baby was seen for a first week visit, skip to Section J.**

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: ______________________________
     ____

H. 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 playmate(s) 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

I. 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

*J. Review of Systems

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

☐ Birthmarks
☐ Blood in stool
☐ Chokes easily
☐ Constipation
☐ Cough
☐ Cradle cap, dry scalp
☐ Diarrhea
☐ Difficulty breathing
☐ Difficulty swallowing
☐ Dry skin
☐ Other______________________
☐ Eyes cross
☐ Feet/legs look funny
☐ Heart murmur
☐ Mattery eyes
☐ Rashes
☐ Red eyes
☐ Skin turns blue in color when eating
☐ Stomachaches
☐ Stuffy / Runny nose
☐ Vomiting
☐ None

K. Active Community Services

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

☐ WIC
☐ Public Health
☐ MFIP
☐ Spiritual
☐ Other ______________________________

Reviewed by ______________________________
(Medical Provider's signature)