Mankato Clinic

Health History 6 - 9 Months

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)?_____	□	□
2. Hospitalizations?_____	□	□
3. Surgery?_____	□	□
4. Serious injuries or accidents?_____	□	□
5. Frequent colds?_____	□	□
6. Frequent ear infections?_____	□	□

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. 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. What type of drinking water? □City □Well □Bottled
   - **If well or bottled,** does your child take fluoride? □Yes □No
5. Does your child spit up much? □Yes □No
6. Is your child eating solids? □Yes □No
   - If so, what types of solids? □Cereal □Fruits □Vegetables □Meats □Table Food
7. Is your child using a cup? □Yes □No
8. Is your child feeding him/herself with their fingers? □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
   Please explain? _____
   _____

C. Sleep

1. Any concerns with sleeping? □Yes □No
2. What time does your child:
   - Go to sleep at night? _____
   - Up in the morning? _____
3. How many naps during the day? _____
   How long is each nap? _____
4. 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 child's personality?
  _____
  _____
  _____

F. Development

1. Do you have any concerns about your child's:
   - vision? □Yes □No
   - hearing □Yes □No
   - development? □Yes □No
2. Does your child move his/her arms and legs well? □Yes □No
3. Do you feel your child is doing what they should be doing for their age? □Yes □No
4. Does your baby respond to your voice? □Yes □No

- **If your child is 6 months old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Reaches for objects		
Fine motor/adaptive		
• Picks up toy with one hand by "raking it up"		
Language		
• Responds to voices: turns head toward a voice		
• Imitates sounds that you make		
• Vocalizes		
Gross Motor		
• Holds head steady when held sitting		
• Rolls over from tummy to back		
• Rolls over from back to tummy		
• Sits alone steady		

- **If your child is 9 months old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Waves bye-bye		
• Recognizes strangers		
Fine motor/adaptive		
• Picks up objects with one hand		
• Feeds self cracker		
• Transfers objects from one hand to the other		
• Holds two objects, one in each hand, at the same time		
• Picks up small objects using precise thumb and finger grasp		
Language		
• Babbles		
• Makes sounds like da-da, ma-ma, ba-ba		
• Imitates sounds that you make		
Gross Motor		
• Crawling		
• Pulls self to standing position		

G. Family

Please answer these questions pertaining to your home:

OR

□ Check (√) this box if nothing has changed since the last well child exam at the Mankato Clinic and skip to section H.

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:

OR

□ Check (√) this box if nothing has changed since the last well child exam at the Mankato Clinic and skip to section I.

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

K. Active Community Services

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

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

Reviewed by _____
(Medical Provider's signature)