Mankato Clinic

Health History 12 - 15 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 12 months old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Plays "pat-a-cake" or "so big"		
• Waves bye-bye		
• Lifts cup to mouth and drinks		
Fine motor/adaptive		
• Puts small objects in cup or other container		
• Feeding self with fingers		
Language		
• Babbles		
• Makes sounds like da-da, ma-ma, ba-ba		
• Single words		
Gross Motor		
• Pulls self to standing position		
• Stands alone briefly		
• Walks without help		

- **If your child is 15 months old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Lifts cup to mouth and drinks		
• Imitaties simple acts such as hugging or loving a doll		
• Points to one body part		
• Knows one animal sound		
• Looks at books		
Fine motor/adaptive		
• Puts small objects in cup or other container		
• Scribbles with crayon or pencil		
• Trying spoon and fork		
Language		
• Says Mama or Dada for parent		
• Says 3 – 5 words		
• Makes many sounds		
Gross Motor		
• Walks without help		
• Stands alone steady		
• Starting to run		
• Climbs		

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. Anyone smoke? □Yes □No
   - If yes, who? _____
4. Any guns? □Yes □No
5. Anyone have a problem with alcohol? □Yes □No
   - If yes, who? _____
6. Anyone have a problem with drugs? □Yes □No
   - If yes, who? _____
7. Do you have any concerns about safety at your house? □Yes □No
   - If yes, please explain: _____
     _____
8. 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
□ 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
□ ECFE
□ Headstart
□ Spiritual
□ Other _____

Reviewed by _____
(Medical Provider's signature)