Mankato Clinic

Health History18mos – 2 years

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:

☐ Anemia (low-iron in blood)
☐ Asthma
☐ Bladder/Kidney infection
☐ Chickenpox
☐ Diabetes
☐ Ear infections
☐ Elevated Lead level
☐ Frequent respiratory infections
☐ Hay fever / Allergies
☐ Meningitis
☐ Pneumonia
☐ Seizures
☐ Sinus infections
☐ Strep infections/ Scarlet Fever
☐ None

MC536e (07/14)

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. Feeding/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. Is your child toilet trained? □Yes □No
2. How often does your child have a stool?________
   ____
   - Any constipation? □Yes □No
   - Diarrhea? □Yes □No
3. 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. How many naps during the day? _____________
   Length of naps? __________________________
4. Any difficulty falling asleep? □Yes □No
5. Does your child have nightmares? □Yes □No
6. 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. Type of drinking water? □City □Well
   - **If well water,** does your child take fluoride? □Yes □No

E. Safety

1. Does your child have a car seat? □Yes □No
2. What type? □ Convertible
   □ Forward-facing
   □ Booster Seat
3. Does your child wear a helmet when riding a tricycle / bicycle? □Yes □No

F. Activity

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. 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: ________________
   ____
   ____
   ____
   ____

H. Daycare

1. Does your child get along well with other children? □Yes □No
2. Does your child like daycare? □Yes □No

I. Development

1. Do you have any concerns about your child's:
   - vision? □Yes □No
   - hearing □Yes □No
   - development? □Yes □No

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

- **If your child is 18 months, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Gives hugs and kisses		
• Lifts cup to mouth and drinks		
• Imitates simple acts such as hugging or loving a doll		
• Points to many body parts		
• Knows several animal sounds		
• Looks at books		
• Points to pictures in book		
Fine motor/adaptive		
• Feeds self with spoon / fork		
• Scribbles with crayon or pencil		
Language		
• Uses at least 10 words		
Gross Motor		
• Climbs		
• Runs		

- **If your child is 2 years old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Feeds self with spoon / fork		
• Takes off open coat or shirt without help		
• Knows many body parts		
• Knows many animal sounds		
• Counts 1 - 2		
Fine motor/adaptive		
• Builds tower of four or more blocks		
Language		
• Uses hundreds of words		
• Puts two words together		
• Follows two-part instructions		
Gross Motor		
• Runs		
• Kicks a ball forward		
• Walks up stairs alone		

J. 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: ______________________

K. 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 L.**

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. Review of Systems

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

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

N. 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)