Mankato Clinic

Health History 3 - 4 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 had any of the following:

□ Anemia (low-iron in blood)
□ Asthma
□ Bladder/Kidney infection
□ Chickenpox
□ Diabetes
□ Ear infections
□ Elevated Lead level
□ Frequent respiratory infections
□ Hayfever / 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. 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 / Preschool (circle what child attends)

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

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 3 years old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Plays with other children		
• Dresses self with help		
• Counts to 5		
• Knows a few colors		
Fine motor/adaptive		
• Draws or copies a line		
• Draws or copies a circle		
Language		
• Speaks clearly—is understandable at least ½ of the time		
• Puts 3 – 5 words into a sentence		
Gross Motor		
• Stands on one foot without support		
• Walks up and down stairs alone		
• Jumps		
• Pedals a tricycle / bicycle		

- **If your child is 4 years old, please answer the following developmental questions:**

Personal/Social/Cognitive	Y	N
• Plays games like "hide and seek"		
• Counts to 10		
• Knows colors		
• Knows shapes		
• Says ABC's		
• Draws a face		
Fine motor/adaptive		
• Cuts across paper with small scissors		
• Writes name		
Language		
• Answers questions like, "What do you do with a cracker? a hat?"		
• Asks questions beginning with "Why? When? How?		
• Uses many words in a sentence		
• Speech is understandable ¾ of the time		
Gross Motor		
• Hops on one foot without support		
• Skips or makes running "broad jumps"		
• Pedals a tricycle / bicycle		

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: _____
     _____
     _____

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. Review of Systems

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

□ Blood in stool
□ Blurry vision/ Difficulty seeing
□ Bruises easily
□ Chokes 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
□ Frequent sore throat
□ Headaches
□ Heart murmur
□ Hoarse sounding voice
□ Mattery eyes
□ Muscle/joint pain
□ Poor activity level/ gets tired easily
□ Rashes
□ Red eyes
□ Stomachaches
□ Stomach cramps
□ Vomiting
□ Walks funny - toes in or out
□ Other _____ _____
□ 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)