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_____

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: _____
_____
_____
_____

*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)? If yes, please explain: □Yes □No _____
   _____
   _____
   _____

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? What are they? _____ □Yes □No
   _____
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	□ 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
□ Spiritual
□ Other _____

Reviewed by _____
(Medical Provider's signature)