

Mankato Clinic Health History

2 - 4 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 _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Foods _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Insect bites _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Immunizations (shots)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Hospitalizations? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Surgery? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Serious injuries or accidents? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Frequent colds? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Frequent ear infections? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

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: _____

MC536b (03/06)

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

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

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

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

Personal/Social/Cognitive	Y	N
• Makes eye contact		
• Social smile		
• Alert/interested in sights and sounds		
Fine motor/adaptive		
• Follows moving objects with eyes		
Language		
• Makes sounds/gurgles/coos		
• Responds to sound		
Gross Motor		
• Lifts head and chest when lying on abdomen		

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

Personal/Social/Cognitive	Y	N
• Smiles, playful		
Fine motor/adaptive		
• Opens hands frequently		
• Holds objects put in hand		
• Holds up hand and looks at it		
Language		
• Laughs out loud		
• Makes sounds		
• Squeals		
Gross Motor		
• Holds head steady when held sitting		
• Rolls over from tummy to back		

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.

- Who lives there? _____
- Any problems/major stressors? Yes No
 - If yes, please explain: _____
- Anyone smoke? Yes No
 - If yes, who? _____
- Any guns? Yes No
- Anyone have a problem with alcohol? Yes No
 - If yes, who? _____
- Anyone have a problem with drugs? Yes No
 - If yes, who? _____
- Do you have any concerns about safety at your house? Yes No
 - If yes, please explain: _____
- 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.

- Does the child live in or frequently visit houses built before 1950? Yes No
- Does the parent/caregiver have contact with lead in their jobs? Yes No
- Do you live near roads with heavy traffic or near lead smelters or processing plants? Yes No
- Has another child in your house or any of your child's playmate(s) had lead poisoning? Yes No
- Do you use any folk medicines with your child? Yes No
- 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:

- | | |
|--|---|
| <input type="checkbox"/> Birthmarks | <input type="checkbox"/> Eyes cross |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Feet/legs look funny |
| <input type="checkbox"/> Chokes easily | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mattered eyes |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Cradle cap, dry scalp | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Skin turns blue in color when eating |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Stomachaches |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Stuffy / Runny nose |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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)