Countryside Pediatric Care

Patient Name: _____ **DOB:** _____

FAMILY HISTORY

Check all diseases below that have occurred in this child's brothers, sisters, parents, grandparents, aunt's uncles or first cousins.

Please **specify who** (in relationship to the child) in the space next to the illness and their approximate age at diagnosis.

- ☐ Asthma
- ☐ Sinus Allergies
- ☐ Eczema
- ☐ Cystic fibrosis
- ☐ Birth defects
- ☐ Seizures
- ☐ ADHD
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack / stroke
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Digestive problems
- ☐ Liver problems
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Anesthesia reactions
- ☐ Depression / anxiety
- ☐ Substance abuse
- ☐ Cancer (specify type)
- ☐ Other _____

TB RISK ASSESSMENT (Check if your child has close contact with an adult who . . .)

- ☐ Is homeless or living in a shelter
- ☐ Is living or working in a prison
- ☐ Is living or working in a nursing home
- ☐ Has TB, HIV, AIDS, or abuses drugs
- ☐ Immigrated from Central or S. America, Haiti, Russia, E. Europe, India, or SE Asia
- ☐ Is a healthcare worker (If yes, are they screened regularly?_____)
- ☐ None of the above

LEAD RISK ASSESSMENT (Check all that apply)

- ☐ Home or daycare built before 1970 ☐ before 1950 ☐ has chipping / peeling paint
- ☐ Child eats dirt, clay, or paint chips ☐ likes to suck on windowsills or blinds
- ☐ Child's friends, playmates, or neighbors with high lead levels
- ☐ Parent's job / hobby involves lead exposure ☐ Folk remedy with lead (Azarcon)
- ☐ None of the above

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PATIENT BIRTH HISTORY – **check italicized options** that apply.

Did mother receive prenatal care? ☐ *Yes* ☐ *No*

Was baby born ☐ *full term* (37-42 weeks) or ☐ *premature* (if preemie, how early? _____)

Was it a ☐ *vaginal delivery* or ☐ *cesarean section* (if c-section, state reason _____)

Did mom have any problems or complications during pregnancy? ☐ *Yes* ☐ *No*
☐ *Diabetes,* ☐ *high blood pressure,* ☐ *preeclampsia,* ☐ *preterm labor,* ☐ *other* _____

Did mom have any of the following infections during pregnancy? *Yes* *No*
☐ *Yeast,* ☐ *herpes,* ☐ *gonorrhea,* ☐ *chlamydia,* ☐ *syphilis* ☐ *HIV,* ☐ *urinary tract infection*

Did mom test positive for group B strep (GBS) during this or a previous pregnancy? ☐ *Yes* ☐ *No*
If yes, did she receive antibiotics during labor? ☐ *Yes* ☐ *No* ☐ *Don't know*

What was the baby's birth weight? _____ Mom's blood type _____

Did baby have any problems in the newborn nursery before hospital discharge? ☐ *Yes* ☐ *No*

☐ *Jaundice,* ☐ *low blood sugar,* ☐ *feeding problems,* ☐ *breathing problems or needed oxygen,*
☐ *Heart murmur,* ☐ *suspicion of infection,* ☐ *sepsis,* ☐ *pneumonia,* ☐ *other* _____

Did he / she have to go to the NICU or special intensive care unit for newborns? ☐ *Yes* ☐ *No*

Was baby at least 24 hours old when the newborn metabolic screen (PKU) was done? ☐ *Yes* ☐ *No*

Did he / she pass the newborn hearing screen with both ears? ☐ *Yes* ☐ *No*

PATIENT MEDICAL HISTORY - Please explain any Yes answers

Any hospitalizations?	☐ No	☐ Yes	_____
Any surgeries?	☐ No	☐ Yes	_____
Any serious injuries, concussions, or broken bones?	☐ No	☐ Yes	_____
Taking any medications, vitamins, herbals, or fluoride?	☐ No	☐ Yes	_____
Any allergies to medications?	☐ No	☐ Yes	_____
Any allergies to foods?	☐ No	☐ Yes	_____
Any reactions to any immunizations?	☐ No	☐ Yes	_____
Any chronic cough or recurrent wheezing or pneumonia?	☐ No	☐ Yes	_____
Ever diagnosed with asthma or reactive airway disease?	☐ No	☐ Yes	_____
Any nasal or sinus allergies?	☐ No	☐ Yes	_____
Any eczema or skin problems?	☐ No	☐ Yes	_____
Any vision or hearing impairments?	☐ No	☐ Yes	_____
History of frequent ear infections?	☐ No	☐ Yes	_____
Any heart problems or heart murmur?	☐ No	☐ Yes	_____
Any stomach or digestive problems?	☐ No	☐ Yes	_____
Any kidney or urinary tract problems?	☐ No	☐ Yes	_____
Any seizures, tics, or migraines?	☐ No	☐ Yes	_____
Any developmental delays or learning disabilities?	☐ No	☐ Yes	_____
Any severe behavioral problems or psychiatric illness?	☐ No	☐ Yes	_____