# PEDIATRIC MEDICAL HISTORY

(Ages 2 months -12 years)

**Patient Name:** **DOB:**

Source of information: [ ] Mother [ ] Father [ ] Family member [ ] Another person

***MEDICAL HISTORY***

List all Allergies (medications/food/environmental) :

No significant Past Medical History [ ]

***Please answer all questions that apply to your Child:***

| | | | |
|---|---|---|---|
| Allergic Rhinitis | □ Yes | Diabetes Mellitus | □ Yes |
| Anemia | □ Yes | Eyesight Problems | □ Yes |
| Asthma | □ Yes | Fracture | □ Yes |
| Attention Deficit Disorder (ADD) | □ Yes | Hearing Loss | □ Yes |
| Attention Deficit Hyperactivity Disorder (ADHD) | □ Yes | Preterm Infant | □ Yes |
| Blood Disorders | □ Yes | Seizure Disorder | □ Yes |
| Cancer Type: | □ Yes | Does your child receive special education | □ Yes |
| Cerebral Palsy | □ Yes | Speech Difficulties | □ Yes |
| Mental Retardation | □ Yes | Gastric Reflux | □ Yes |

Is your child presently taking medication? □ Yes □ No - If yes, please list what medications, strength and for what condition?

***HOSPITALIZATION/ SURGICAL HISTORY***

Please list below all surgeries and previous hospitalizations? □ Yes □ No - Reason(s) / Date(s)?

***SOCIAL HISTORY***

***Please check all that apply to your Child:***

| | | | |
|---|---|---|---|
| Lives with Parents | □ Yes | Currently in school | □ Yes |
| Foster Home | □ Yes | Child in Day Care | □ Yes |
| Group Home | □ Yes | Exposed to cigarette smoke at home | □ Yes |
| Other: _____ | □ Yes | Guns in home | □ Yes |

***FAMILY HISTORY***

***Please check (✓) if any of these apply to any of your Child's family member***

| Family History | Mom | Dad | Siblings | Grandparent |
|---|---|---|---|---|
| Alcoholism | | | | |
| Blood Disorders | | | | |
| Cancer Type: | | | | |
| Diabetes Mellitus | | | | |
| Drug Use | | | | |
| Genetic Disorder | | | | |
| High Cholesterol | | | | |
| Hypertension | | | | |
| Kidney Disease | | | | |
| Seizure Disorder | | | | |
| Sickle Cell | | | | |
| Stroke | | | | |
| Thyroid Disorders | | | | |

**Name of Person completing form:** _____ **Date:** _____

# Staying Healthy Assessment

## 9 – 11 Years

| Child's Name (first & last) | Date of Birth | ☐ Female ☐ Male | Today's Date | Grade in School: |
|---|---|---|---|---|
| Person Completing Form | ☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify) | | | School Attendance Regular? ☐ Yes ☐ No |

*Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.*

Need Interpreter? ☐ Yes ☐ No

| | | | | | Clinic Use Only: |
|---|---|---|---|---|---|
| | | | | | Nutrition |
| 1 | Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu? | Yes | No | Skip | |
| 2 | Does your child eat fruits and vegetables at least two times per day? | Yes | No | Skip | |
| 3 | Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week? | No | Yes | Skip | |
| 4 | Does your child drink more than one cup (8 oz.) of juice per day? | No | Yes | Skip | |
| 5 | Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week? | No | Yes | Skip | |
| | | | | | Physical Activity |
| 6 | Does your child exercise or play sports most days of the week? | Yes | No | Skip | |
| 7 | Are you concerned about your child's weight? | No | Yes | Skip | |
| 8 | Does your child watch TV or play video games less than 2 hours per day? | Yes | No | Skip | |
| | | | | | Safety |
| 9 | Does your home have a working smoke detector? | Yes | No | Skip | |
| 10 | Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone? | Yes | No | Skip | |
| 11 | Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")? | Yes | No | Skip | |
| 12 | Does your child spend time near a swimming pool, river, or lake? | No | Yes | Skip | |
| 13 | Does your child spend time in a home where a gun is kept? | No | Yes | Skip | |
| 14 | Does your child spend time with anyone who carries a gun, knife, or other weapon? | No | Yes | Skip | |
| 15 | Does your child always wear a helmet when riding a bike, skateboard, or scooter? | Yes | No | Skip | |

| | | | | | |
|---|---|---|---|---|---|
| 16 | Has your child ever witnessed or been a victim of abuse or violence? | No | Yes | Skip | |
| 17 | Has your child been hit or has your child hit someone in the past year? | No | Yes | Skip | |
| 18 | Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)? | No | Yes | Skip | |
| 19 | Does your child brush and floss her/his teeth daily? | Yes | No | Skip | Dental Health |
| 20 | Does your child often seem sad or depressed? | No | Yes | Skip | Mental Health |
| 21 | Does your child spend time with anyone who smokes? | No | Yes | Skip | Alcohol, Tobacco, Drug Use |
| 22 | Has your child ever smoked cigarettes or chewed tobacco? | No | Yes | Skip | |
| 23 | Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high? | No | Yes | Skip | |
| 24 | Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor? | No | Yes | Skip | |
| 25 | Does your child have friends or family members who have a problem with drugs or alcohol? | No | Yes | Skip | |
| 26 | Has your child started dating or "going out" with boyfriends or girlfriends? | No | Yes | Skip | Sexual Issues |
| 27 | Do you think your child might be sexually active? | No | Yes | Skip | |
| 28 | Do you have any other questions or concerns about your child's health or behavior? | No | Yes | Skip | Other Questions |

*If yes, please describe:*

| ***Clinic Use Only*** | Counseled | Referred | Anticipatory Guidance | Follow-up Ordered | Comments: |
|---|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ | |
| ☐ Physical activity | ☐ | ☐ | ☐ | ☐ | |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ | |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ | |
| ☐ Mental Health | ☐ | ☐ | ☐ | ☐ | |
| ☐ Alcohol, Tobacco, Drug Use | ☐ | ☐ | ☐ | ☐ | |
| ☐ Sexual Issues | ☐ | ☐ | ☐ | ☐ | ☐ **Patient Declined the SHA** |

| PCP's Signature: | Print Name: | Date: |
|---|---|---|

**SHA ANNUAL REVIEW**

| PCP's Signature: | Print Name: | Date: |
|---|---|---|
| PCP's Signature: | Print Name: | Date: |

# Tuberculosis Risk Assessment Screening Questionnaire

**Today's Date:** _____

**Name:** _____ **Date of Birth:** _____

*If your child has the appointment today, please fill out the form as it pertains to the child.

| **Circle any symptoms you are experiencing today:**<br>Cough Fever Loss of Appetite Coughing Up Blood Fatigue Weight Loss Night Sweats | | |
|---|---|---|
| 1. Have you ever had a **positive** TB Skin Test or **positive** TB Blood Test (Quantiferon Level)?<br>**(If YES, also answer A-D below). (If NO, skip to Question #2).**<br>_____<br>**Answer only if history of positive TB Test:**<br>A. Date of positive test? _____<br>B. Date of last chest x-ray? _____ Normal: **Yes** **No**<br>C. Was a preventive treatment for tuberculosis taken (such as INH)? **Yes** **No**<br>D. Preventative treatment dates? _____ | YES | NO |
| 2. Have you had any of the following vaccines: Measles/Mumps/Rubella, Varicella, Zostavax or Nasal flu vaccine in the past 4 weeks? | YES | NO |
| 3. Do you have close contact with someone who has, active Tuberculosis? | YES | NO |
| 4. In the last 5 years have you lived or worked in prison, hospital, nursing home, homeless shelter, foster care or group home? | YES | NO |
| 5. Were you born in Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico? | YES | NO |
| 6. In the last 2 years have you traveled to Asia, Africa, Latin America, Caribbean, Eastern Europe, Pacific Islands, South America, or Mexico? | YES | NO |
| 7. Are you currently homeless, a migrant worker, or use street drugs? | YES | NO |

I have received information about the TB skin test and have had the opportunity to ask any questions which were answered to my satisfaction. I agree to return in **48-72 hours** to have my TB test read. I understand the risks and benefits of the TB skin test and request the test be administered to me. I understand that if I am symptomatic for TB, or the TB skin test is positive, I will need to follow up with my Primary Care Physician and further treatment may be necessary.

**Form Completed By (Signature):** _____ **Date:** _____

**Print Name:** _____

**Relationship to Patient:** (Self), (Parent), (Guardian), Other): _____

# Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | yes | no | don't know |
|---|---|---|---|
| **1.** Is the child sick today? | ☐ | ☐ | ☐ |
| **2.** Does the child have allergies to medications, food, a vaccine component, or latex? | ☐ | ☐ | ☐ |
| **3.** Has the child had a serious reaction to a vaccine in the past? | ☐ | ☐ | ☐ |
| **4.** Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy? | ☐ | ☐ | ☐ |
| **5.** If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months? | ☐ | ☐ | ☐ |
| **6.** If your child is a baby, have you ever been told he or she has had intussusception? | ☐ | ☐ | ☐ |
| **7.** Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? | ☐ | ☐ | ☐ |
| **8.** Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems? | ☐ | ☐ | ☐ |
| **9.** In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? | ☐ | ☐ | ☐ |
| **10.** In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? | ☐ | ☐ | ☐ |
| **11.** Is the child/teen pregnant or is there a chance she could become pregnant during the next month? | ☐ | ☐ | ☐ |
| **12.** Has the child received vaccinations in the past 4 weeks? | ☐ | ☐ | ☐ |

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

**Did you bring your immunization record card with you?** **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf ▪ Item #P4060 (9/17)

# What Do You Eat?
(Ages 8-19)

**Circle the names of foods you eat often:**

## Iron/Protein

Chicken/Turkey Ham/Pork Seafood Eggs Tofu
Hamburger Fried Chicken Tacos Peanut Pizza
Whole Grain Bread Peanut Butter Cereal Rice Hot dog
Meat/Bean Burrito Noodle Soup Tortilla Beef Pasta
Sweet Bread Beans/Lentils White Bread Potato Dark
Green Leafy Vegetables Spaghetti with Meatballs

## Fruits and Vegetables

Cucumber Broccoli Banana 100% Juice Pear Pea
Pineapple Bell pepper Orange Carrots Apple Mango
Cantaloupe Chili Pepper Tomato Grapes Potato Corn
Green Salad Cabbage Green Beans Peach Melon Strawberry
Dark Green Leafy Vegetables Sweet Potato

## Snack

Chocolate French Fries Fruit Pie Donut Candies
Vegetables Cheese Puffs Chips Cookies Bagels
Mexican Bread Popcorn Pretzels Crackers Fruits

## Drinks

Sports Drinks 100% Fruit Juice Wine Soda
Alcoholic Drink Flavored Drinks Coffee Beer
Sweetened Tea Wine Cooler Herbal Tea Tea
Fruit Flavored Soda Coffee Drink Energy Drinks Water

## Calcium

Almond butter Nonfat Milk Whole Milk 2 % Milk Prunes
1 % Lowfat Milk Tempeh Tahini Yogurt Beans
Lactose Free Milk Ice Cream Dried Figs Cheese Tofu
Cottage Cheese Milkshake Soy Beans Almonds Corn
Green Leafy Vegetables Orange Tortilla
Calcium Fortified 100% Juice Calcium Fortified Soy/Plant Milk

**Name:** _____ **Age:** _____ **Date of Birth:** _____

**Wt:** _____lbs **Ht:** _____in **BMI:** _____ **BMI %ile:** _____ **Date:** _____

DHCS 4035 B (05/16) Adapted from the CHDP Programs of Orange County and San Bernardino Counties

*Office use only:*

*Circle to indicate the topics discussed:*

Healthy eating
Regular meals/snacks
Importance of breakfast
inadequate food supply
Low fat dairy foods
High sugar foods
Other: _____

**Iron/Protein**

2-3 servings daily
High iron foods
Plant protein sources such as beans, peas, lentils, nuts, etc.
Limit high fat foods

**Fruits and Vegetables**

2-4 fruits daily or more
3-5 vegetables daily or more
Vitamin C sources
Vitamin A sources

**Calcium**

3-4 servings dairy foods/day
Nonfat or 1 % milk Lowfat dairy choices Low lactose alternative Calcium fortified foods
Other food sources of calcium

**Snacks**

High-sugar snacks
High-fat snacks
Fruit/vegetable snacks
Fast foods

**Drinks**

< 8-12 oz/day 100% juice
6-8 glasses of water (8 ounces each)/day
Sweetened drinks
Alcohol/caffeine

**Referred for identified nutrition problem?** **Yes** **No**

If yes, where: _____

Provider initials: _____

# Youth Nutrition and Activity Assessment

(Ages 8 - 19)

***Provide additional information about your food, activity and habits:***

## Eating Habits

Do you eat or drink the following meals? Circle one answer per meal.

| | | | | |
|---|---|---|---|---|
| Breakfast | **Always** | **Usually** | **Occasionally** | **Never** |
| Morning snack | **Always** | **Usually** | **Occasionally** | **Never** |
| Lunch | **Always** | **Usually** | **Occasionally** | **Never** |
| Afternoon snack | **Always** | **Usually** | **Occasionally** | **Never** |
| Dinner | **Always** | **Usually** | **Occasionally** | **Never** |
| Evening Snack | **Always** | **Usually** | **Occasionally** | **Never** |

## Exercise/Physical Activity

How many hours a day do you?

Watch TV _____hours/day

Use a smart phone _____hours/day

Play video/computer games _____hours/day

Use the internet _____hours/day

Do you participate in physical education classes at school? **Yes** **No**

Circle all that you participate in:

| | | | |
|---|---|---|---|
| Walking | Running | Bicycling | Swimming |
| Dance | Yoga | Martial Arts | Rollerblading |
| Basketball | Softball | Soccer | Volleyball |

Other activities or team sports: _____

How often are you physically active?

_____times/week _____minutes/day

## Weight/Body Image

Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned

Do you eat less to control your weight? **Yes** **No**

Explain: _____

Have you ever made yourself vomit? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Do you ever "binge" eat? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Circle any of the following that you use:

| | | | |
|---|---|---|---|
| Diet pills | Laxatives | | |
| Multivitamins | Calcium | Iron | Vitamin D |
| Protein powder | Nutrition supplements | | Steroids |

What, if any, other products do you use?

Explain: _____

*Office use only*

*Complete assessment below using all information provided:*

## Eating Habits

| | | |
|---|---|---|
| Overall diet adequate | **Yes** | **No** |
| 3 meals and snacks | **Yes** | **No** |
| High iron foods | **Yes** | **No** |
| Calcium foods | **Yes** | **No** |
| 5 or more fruits/vegetables | **Yes** | **No** |
| Adequate fluids | **Yes** | **No** |

## Exercise/Physical Activity

Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day **Yes** **No**

Goal set: _____

Engages in physical activity (60 minutes/day or more) **Yes** **No**

Goal set: _____

Referral made **Yes** **No**

Referred to: _____

## Weight/Body Image

BMI %ile _____ Date _____

- ☐ ***BMI between 5th and 85th %iles***
- ☐ ***BMI ≤ 5th %ile***
- ☐ ***BMI between 85th and 95th %iles***
- ☐ ***BMI ≥ 95th %ile***

Signs of eating disorder **Yes** **No**

Counseling given **Yes** **No**

Topics: _____ Goal set: _____

Referral made **Yes** **No**

Referred to: _____