NEW PEDIATRIC PATIENT – BIRTH TO 1 YEAR

CLAY PLATTE FAMILY MEDICINE
SUMMIT FAMILY AND SPORTS MEDICINE
COBBLESTONE FAMILY MEDICINE CLINIC
BARRY POINTE FAMILY CARE

Name: _____

Birth Date: _____ Sex: M F

Today's Date: _____

Please tell us the **REASON FOR TODAY'S VISIT**: _____

Please list **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea, swelling)

Are **IMMUNIZATIONS** up to date? Yes No **Please provide a copy of immunization record.**

BIRTH HISTORY:

Mother's age at child's birth: _____	Type of Delivery: _____Vaginal _____C-Section
Number of pregnancies: _____	Term: _____Full Term _____Premature
Was prenatal care given: Yes No	Birth Weight: _____lbs _____oz
Any problems after delivery or newborn nursery care? Yes No	Birth Length: _____inches

DEVELOPMENTAL HISTORY

Please complete most current age-appropriate section for your child:

Birth to 6 Weeks	Yes	No
Focuses on care-taker's face		
Lifts head		
Responds to sound		
Turns head side to side		
2 Months	**Yes**	**No**
Coos		
Fixes on Objects and follows movement		
Follows past midline		
Grasps		
Lifts head to 45 degrees		
Smiles responsively		
Turns head to sound		
Vocalizes		

4 Months	Yes	No
Bears Weight		
Coos, squeals, laugh		
Follows 180 degrees		
Grasps		
Holds head/chest up with support		
Holds small toy		
No head lag		
Reaches		
Rolls		
Turns to sound		
6 Months	**Yes**	**No**
Babbles		
Bears weight		
Laughs		
Pulls to sit		
Responds to name		
Rolls both ways		
Sits alone		
Transfers objects		

For Nurse Use Only: Height_____ Weight_____ Temp_____ BP_____ Pulse_____ Resp_____

DEVELOPMENTAL HISTORY - Continued

Please complete most current age-appropriate section for your child:

9 Months	Yes	No
Babbles consonant sounds		
Claps, waves, peek-a-boo		
Creeps, crawls		
Cruises		
Gets to sit		
Mama/Dada		
Pat-a-cake		
Pincer grasps		
Pulls to stand		
Shake, bank, throw		
Sits alone		
Stands with support		

12 Months	Yes	No
Cruises		
Fills and empties containers		
Finds hidden objects		
Gets to sit		
Holds cup and drinks		
Imitates words		
Pincer grasp		
Stands alone		
Turns pages		
Verbal skills: 1 to 2 words		
Walks alone		

Please provide your **PAST MEDICAL HISTORY** and **SURGICAL HISTORY** date/year if known: _____

_____

_____

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Allergies					
Asthma					
Birth Defects					
Cancer, Type					
Coronary artery disease (heart disease)					
Deafness					
Depression					
Developmental delay					
Diabetes					
Eczema					
Genetic disorder					
Hemoglobinopathy					

	Mother	Father	Sister	Brother	Other
High cholesterol					
High blood pressure					
Hip Dysplasia					
Learning disability					
Mental retardation					
Migraines DDH					
Obesity					
Scoliosis					
Seizure disorder					
SIDS					
Strabismus (crossed eyes)					
Thyroid disease					
Other:					

Please provide your **SOCIAL HISTORY**:

Who lives with your child? _____

Who provides care for your child? _____

Tobacco Exposure	Yes	No
Are there smokers in the house?		
If yes, do they smoke outside only?		
Home Environment	**Yes**	**No**
What is the age of the home?		
Is the water chlorinated?		
Is the water fluoridated?		
Is there lead in the home?		
Sleep	**Yes**	**No**
Does child take naps?		
Does child sleep in bed with parents?		
Does child sleep through the night?		

Sleep (continued)	Yes	No
Does child get 8.5 hours of sleep?		
Does child have sleeping problems?		
What position does child sleep in?		
Safety	**Yes**	**No**
Do you use a car seat?		
Is yes, which way is car seat facing?		
Are smoke detectors in the home?		
Is there a carbon monoxide detector?		
Are there firearms in the home?		
Are there pets in the home?		
If yes, what kind(s)?		