

**SERIOUS INJURIES OR ACCIDENTS DATES:**

Immunizations and Dates:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | #1 | #2 | #3 | #4 | #5 |
| DTaP |  |  |  |  |  |
| Polio |  |  |  |  |  |

Measles, Mumps, Rubella (MMR) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TB Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BCG\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (Typhoid, cholera, small pox) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVELOPMENTAL:** Age child: Sat up\_\_\_\_\_\_\_\_\_\_ Crawled \_\_\_\_\_\_\_\_\_\_\_Walked \_\_\_\_\_\_\_\_\_\_

Toilet Trained \_\_\_\_\_\_\_\_\_\_ Talked in phrases \_\_\_\_\_\_\_\_\_\_\_

**DAYCARE:** Home based Center based

**EXPOSURE TO CIGARETTE SMOKE:** Yes No

**FIREARMS IN HOME:** Yes No

**REVIEW OF SYSTEMS:**

Does your child have, or has he/she ever had: (circle yes or no)

**INFECTIOUS DISEASE GASTROINTESTIONAL**

Chicken Pox Yes No Frequent abdominal pain Yes No

if yes when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Constipation Yes No

HIV/AIDS Yes No

Sexually transmitted disease Yes No **GENITOURINARY**

Bladder or kidney infection Yes No

**ENT** Bed wetting (after 5 yrs old) Yes No

Frequent ear infections Yes No

Problems with hearing or ears Yes No **ENDOCRINE**

Thyroid or other endocrine problems Yes No

**ALLERGIES** Diabetes Yes No

Food or environment Yes No

**SKIN**

**EYES** any chronic or recurrent skin problem Yes No

Problem with eyes or vision Yes No (acne, eczema, etc.)

**RESPIRATORY NEUROLOGICAL**

Asthma Yes No Frequent headaches Yes No

Frequent bronchitis or pneumonia Yes No Convulsions or other neurological Yes No

Recurrent croup Yes No Concussion Yes No

Tuberculosis or positive TB skin test Yes No **PSYCHIATRIC**

Other chronic or serious lung disease Yes No Behavior disorder (ADHA, ODD) Yes No

Emotional disorder or suicide attempt Yes No

**CARDIAC** Psychiatric disorder Yes No

High Blood Pressure Yes No Use of alcohol or drugs Yes No

High Cholesterol Yes No

Heart murmur Yes No **GENITOURINARY**

Congenital or acquired heart defect Yes No (for girls) has she started menstrual period

Yes No

**HEMOTOLOGY**  (for girls) any difficulties with menstrual period

Yes No

Anemia or bleeding problem Yes No

Blood transfusion Yes No

Cancer Yes No