NEW / WELL PEDIATRIC PATIENT 1 Year through 4 YEARS

Name:______________________________ Date of Birth:_______________

Sex: Male☐ Female☐

Today's Date:____________________________

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

____

____

Please list your **CURRENT MEDICIATIONS:**

Name of Medication	Dosage (ie, MG)	How Taken (ie, 1 tablet daily)

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

Allergy	Type of Reaction (ie, rash, nausea

Are **IMMUNIZATIONS** up to date? Yes☐ No☐

IMMUNIZATION PREFERENCE (circle one): **Traditional** ☐ **Delayed** ☐ **None** ☐

INTERVAL HISTORY:

Nutritional Detail
Liquids:
Is child breast or bottle fed? ☐ Breast ☐ Bottle
If breast, how often? _____ _____ oz/feeding
If bottle, how often? _____ _____ oz/feeding Type of formula: ___________

Does your child drink ☐ Milk _____ oz/serving
☐ Juice _____ oz/serving
☐ Water _____ oz/serving
Solids:
Child's diet is best described as: ☐ adequate varied diet
☐ excess junk food

Elimination Habits – Bladder
Any concerns about child's bladder or kidney health? Yes☐ No☐
Number of wet diapers per day: _____ times/day
Urine color: ____________________
Urine stream: ____________________
Is child toilet trained (bladder)? Yes☐ No☐

Elimination Habits – Bowel:
Any concerns about child's bowel habits? Yes☐ No☐
Number of bowel movements (BM's): _____ times/day
Stool color: _______________________
Stool consistency: ______________________
Is child toilet trained? Yes☐ No☐

For Nurse Use Only: Ht_________ Wt______ Temp_________ Pulse________ Resp______ H.C. ______

DEVELOPMENTAL HISTORY:

DEVELOPMENTAL HISTORY:

12 Months	Yes	No	15 Months	Yes	No	18 Months	Yes	No
Cruises	☐	☐	Climbs Furniture	☐	☐	8 or more words	☐	☐
Fills and empties containers	☐	☐	Dances	☐	☐	Follows simple directions	☐	☐
Finds hidden objects	☐	☐	Jargon	☐	☐	Feeds self	☐	☐
Gets to sit	☐	☐	Rides Toys	☐	☐	Knows 2 or more body parts	☐	☐
Holds cup and drinks	☐	☐	Stands Alone	☐	☐	Imitates housework	☐	☐
Imitates words	☐	☐	Stoops and recovers	☐	☐	Names pictures	☐	☐
Pincer grasp	☐	☐	Throws Ball	☐	☐	Rides toys	☐	☐
Stands alone	☐	☐	Uses cups only	☐	☐	Runs	☐	☐
Turns pages	☐	☐	Uses spoons	☐	☐	Uses spoons/forks	☐	☐
Verbal skills: 1-2 words	☐	☐	Verbal Skill: 4 words	☐	☐	Walks backwards	☐	☐
Walks alone	☐	☐				Walks up/down stairs	☐	☐

2 Years		No	3 Years		No	4 Years		No
2-word sentences	☐	☐	3-5-word sentences	☐	☐	4-5-words sentences	☐	☐
Acts worried if you're sad	☐	☐	Asks why and what?	☐	☐	Catches ball	☐	☐
Follows 2-part verbal command	☐	☐	Balances on one foot	☐	☐	Cuts and pastes	☐	☐
Gets along with family	☐	☐	Builds 10 block tower	☐	☐	Draws people	☐	☐
Helps dress self	☐	☐	Copies circle and X	☐	☐	Dresses and undresses	☐	☐
Holds cup in one hand	☐	☐	Counts to 3	☐	☐	Enjoys jokes	☐	☐
Jumps with both feet	☐	☐	Dresses self	☐	☐	Jumps/hops	☐	☐
Kicks a ball	☐	☐	Knows name/age/gender	☐	☐	Names 4-5 colors	☐	☐
Removes clothes	☐	☐	Pedals tricycle	☐	☐	Pedals tricycle	☐	☐
Runs	☐	☐	Plays with other kids	☐	☐	Plays well with others	☐	☐
Scribbles	☐	☐	Recognizes 3 colors	☐	☐	Walks on tiptoe	☐	☐
Throws over hand	☐	☐	Toilet trained	☐	☐			
Walks stairs	☐	☐	Walks stairs alternating feet	☐	☐			

Please provide age-appropriate **SOCIAL HISTORY:**

Primary Residence:
Who lives with your child? ___________________
____

Tobacco Exposure:
Are there smokers at home? Yes ☐ No ☐
If yes, do they smoke outside only? Yes ☐ No ☐

Home Environment:
What is the age of the home: ____________
Is water Chlorinated? Yes ☐ No ☐
Is water Fluorinated? Yes ☐ No ☐
Is there lead in the home? Yes ☐ No ☐

Education:
School Name: _________________________
School Grade: _________________________
Does child have any learning disabilities? Yes ☐ No ☐
Does child have any special needs? Yes ☐ No ☐

Child Care:
Who provides care for your child? #days/wk:
☐ Mother _____ days/wk
☐ Father _____ days/wk
☐ Grandparent _____ days/wk
☐ Other ___________ _____ days/wk
☐ Day Care _____ days/wk

Activity:
Exercise/Sports: _____ hrs/day
TV/Computer Games: _____ hrs/day

Sleep:
Does child get 8.5 hrs of sleep? Yes ☐ No ☐
Does child have sleeping problems? Yes ☐ No ☐
Does child take naps? Yes ☐ No ☐
Does child sleep with parents? Yes ☐ No ☐
Does child sleep through the night? Yes ☐ No ☐
What position does child sleep in?: ___________________
____

Safety:
Do you use a car seat? Yes ☐ No ☐
If yes, is car seat facing: Front ☐ Rear ☐
Does child use bike/skate helmet? Yes ☐ No ☐
Does child use seatbelt in the car? Yes ☐ No ☐
Is there a carbon monoxide detector? Yes ☐ No ☐
Are smoke detectors in the home? Yes ☐ No ☐
Are there firearms in the home? Yes ☐ No ☐
Are there pets in the home? Yes ☐ No ☐
If yes, what kind? _____________________________

Please provide your child's **PAST MEDICAL HISTORY** & **SURGICAL HISTORY** date/year if known:

____
____

Please provide your child's **FAMILY HISTORY:**

FATHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? ____________
Health Problems____

MOTHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? ____________
Health Problems____

BROTHERS AND SISTERS: (each one, are they living?, what die from?, ages, other health problems)

____
____
____

OTHER: (NAMES AND AGES, living or deceased, what die from?, ages, other health problems)

____
____
____

Does anyone in the family have these health conditions? (Please check even if listed above)

- ☐ Heart Problems (heart attacks, heart failure)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Diabetes
- ☐ Strokes
- ☐ Mood disorders (anxiety, depression, bipolar, etc.)

HEALTH MAINTENANCE: (Please list Date)

Last Dental Appointment: __________________________
Last Eye Doctor Appointment: ______________________

PATIENT SIGNATURE: ____ **DATE:** __________________

PHYSICIAN REVIEWED: ____ **DATE:** __________________