

# blackmon



## pediatrics

### Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

Who has brought patient in today? \_\_\_\_\_

### Can you describe your child's nutritional habits?

- |                           |        |          |        |         |
|---------------------------|--------|----------|--------|---------|
| 1. Milk:                  | Whole  | Low-fat  | Soy    |         |
| 2. Appetite:              | Good   | Variable | Picky  |         |
| 3. Water Source:          | City   | Well     | Spring | Bottled |
| 4. Variety of foods       | Fruits | Veggies  | Breads | Meats   |
| 5. Multivitamin with iron | Yes    | No       |        |         |
| 6. Eats Breakfast:        | Yes    | No       |        |         |
| 7. Eats supper as family  | Yes    | No       |        |         |

### Is there any problems with hearing and vision?

- |  |     |    |  |     |    |
|--|-----|----|--|-----|----|
| 1. Do you have concerns about how your child sees? | Yes | No | 4. Do you have concerns about how your child hears?  | Yes | No |
| 2. Has your child failed a school vision test?     | Yes | No | 5. Do you have concerns about how your child speaks? | Yes | No |
| 3. Does your child tend to squint?                 | Yes | No |  |     |    |

Has there been any foreign travel in the past 60 days or foreign adoption? Yes No

Has there been any exposure to smoking? Yes No Who: \_\_\_\_\_

### Lead Screening (please answer for ages 2 year, 3 year, 4 year, 5 year, and 6 year)

- |   |     |    |
|---|-----|----|
| 1. Does your child live in or regularly visit a house built before 1950?                                      | Yes | No |
| 2. Does your child live in or regularly visit a house built before 1978 with recent renovations?              | Yes | No |
| 3. Does your child have a sibling or playmates that have or have had lead poisoning?                          | Yes | No |
| 4. Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking? | Yes | No |

### Immunizations

- |   |     |    |
|---|-----|----|
| 1. Previous reaction to immunizations                     | Yes | No |
| 2. Have family members been immunized (mom, dad, sibling) | Yes | No |
| 3. History of chicken pox in child being seen             | Yes | No |
| 4. Serious illness at home or relatives (cancer)          | Yes | No |
| 5. Allergic to eggs, gelatin, Neomycin, yeast             | Yes | No |

### Please describe your social history.

- |                      |                      |
|----------------------|----------------------|
| 1. Race: _____       | 4. Ethnicity: _____  |
| 2. Language: _____   | 5. # Siblings: _____ |
| 3. Lives With: _____ |                      |

Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood) Yes No Specify \_\_\_\_\_

### Have there been any changes in your child's medical needs?

- |  |     |    |                |
|--|-----|----|----------------|
| 1. New Problems or illness   | Yes | No | Specify: _____ |
| 2. Please list current medications (prescription and over-the-counter) _____ |     |    |                |