Name________________________ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your child's...

	YES	NO
1. feedings ☐ breast ☐ whole milk ________	☐	☐
☐ solids? ________	☐	☐
Is he/she still taking the breast or bottle?	☐	☐
2. excessive spitting or vomiting	☐	☐
3. bowel movements	☐	☐
4. straining with stools	☐	☐
5. straining or crying with voiding	☐	☐
6. congestion or wheezing	☐	☐
If present, does this clear with sleeping?	☐	☐
7. skin color or skin rashes (circle)	☐	☐
8. excessive whining, fussing or crying	☐	☐
9. communication skills	☐	☐
10. overall development	☐	☐
11. sleep habits	☐	☐
Does he/she sleep through the night?	☐	☐
If not, does he/she feed during the night?	☐	☐
Does he/she require rocking to get to sleep?	☐	☐

Does your child...

	YES	NO
12. say 3-6 words clearly	☐	☐
13. understand simple commands or requests	☐	☐
14. listen to a story	☐	☐
15. indicate his / her wants by pulling, pointing, grunting	☐	☐
16. point to one or more body parts	☐	☐
17. show fear, anger, affection, jealously	☐	☐
18. become shy or anxious with strangers	☐	☐
19. feed self with fingers	☐	☐
20. drink from a cup	☐	☐
21. cooperate while dressing	☐	☐
22. walk well, stoop and climb stairs	☐	☐
23. stack two blocks	☐	☐
24. Do you have smoke alarms in your house?	☐	☐
25. Is your child exposed to cigarette smoke?	☐	☐
26. Is your child attending day care?	☐	☐
27. Does your child ride in a safety seat in the back seat?	☐	☐
28 Do you know infant CPR?	☐	☐
29. Does anyone have a gun in the home?	☐	☐

Lead Screen

Does your child...

	YES	NO
1. Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative)	☐	☐
2. Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?	☐	☐
3. Have a sibling or playmate who now has or did have lead poisoning?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

____

____

Parent's Signature ________________ Date ________

Parent's section reviewed by________________

History

☐ Previous concerns, consults and procedures reviewed

(Interval: ☐ No Change) Concerns ________________

____

Current Medications ________________

Drug Allergies ☐ Yes ☐ No ________________

Past / Social / Family History

(Interval: ☐ No Change)

____

Provider Comments

____

Anticipatory Guidance

General	*Nutrition*	*Injury Prevention*
☐ Growth /Dev.	☐ Milk	☐ Car seat
☐ Immunizations	☐ Dc. bottle	☐ Burns
☐ Behavior	☐ Table foods	☐ Electric outlets
☐ Discipline	☐ Safe foods	☐ Gates / safety guards
☐ Sleep	☐ Proper snacks	☐ No dangling cords
☐ Mattress (lower)	☐ Feeds self	☐ Poisons
☐ Dental care	☐ Variable appetite	☐ Poison Center #
☐ Passive smoke	☐ Vitamins/Fl.	☐ Water safety
☐ TB risk	☐ Juice	☐ Sun exposure
☐ Ed. Handouts		☐ Gun safety