Name_____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your child's…	YES	NO
1. feedings ☐ 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	☐	☐
7. frequent colds or ear infections	☐	☐
8. skin color or skin rashes (circle)	☐	☐
9. excessive whining, fussing or crying	☐	☐
10. communication skills	☐	☐
11. overall development	☐	☐
12. 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 he/she use a pacifier?	☐	☐
Does your child…		
13. say 15-20 words clearly	☐	☐
14. use two word phrases and imitate words	☐	☐
15. understand and respond to simple requests	☐	☐
16. listen to a story	☐	☐
17. identify a toy by name, e.g. "ball", "car"	☐	☐
18. know 4-5 body parts	☐	☐
19. show fear, anger, affection, jealously	☐	☐
20. insist on feeding him/her self	☐	☐
21. use a spoon and cup	☐	☐
22. cooperate while dressing	☐	☐
23. stand upright from a crouched position	☐	☐
24. run and climb well	☐	☐
25. stack 3-4 blocks	☐	☐
26. Do you have smoke alarms in your house?	☐	☐
27. Is your child exposed to cigarette smoke?	☐	☐
28. Is your child attending day care?	☐	☐
29. Does your child ride in a safety seat in the back seat?	☐	☐
30 Do you know CPR?	☐	☐
31. Does anyone have a gun in the home?	☐	☐

Lead Screen

Does your child…		
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 / amount	☐ Car seat
☐ Immunizations	☐ No bedtime bottle	☐ Burns
☐ Behavior	☐ Nutritious foods	☐ Electric outlets
☐ Discipline	☐ Proper snacks	☐ Gates / safety guards
☐ Sleep	☐ Avoid snack rewards	☐ No dangling cords
☐ Toilet training	☐ Variable appetite	☐ Poisons
☐ Dental care	☐ Vitamins/Fl.	☐ Poison Center #
☐ Passive smoke	☐ Limit juice	☐ Water safety
☐ Ed. Handouts		☐ Sun exposure
		☐ Gun safety

