Name	Date/
THIS SECTION TO BE COMPLETED BY PARENT	History Previous concerns, consults and procedures reviewed
Review of Systems	(Interval: No Change) Concerns
Are you concerned about your child's (circle concerns) YES NO	
1. eating habits, weight loss, ♦ energy, sleep habits	
2. redness, excessive tearing or discharge from eyes	
3. recurrent ear, sinus or throat infections; nosebleeds	
4. chest pain, shortness of breath, or irregular heart beat	
5. frequent colds, cough, wheezing, recurrent bronchitis	And any and the second
6. abdominal pain, vomiting, diarrhea, constipation	
7. urinary control, bed wetting, urinary infections	
8. joint pain, stiffness, swelling; muscle pain, weakness	Current Medications
9. birthmarks, skin rashes, itching, nail or hair problems	
10. recurrent headaches, dizziness, tics, weakness, seizures	Drug Allergies ☐ Yes ☐ No
11. mood changes, sadness, nervous problems	Drug Allergies Yes No
12. excessive thirst or hunger, ↑urination, weight loss	
13. paleness, anemia, easy bruising, swollen glands	Past / Social / Family History (Interval: ☐ No Change)
14. milk, food or drug allergies, recurrent infections	No. 17. A residence of the second
Personal/Social History	
Does your child YES NO	
a. talk well, using long meaningful sentences	
b. tell simple stories and nursery rhymes	
c. watch television program 20-30 minutes	
d. know full name, address, telephone number, 911	
e. understand 2-3 step instructions	
f. sing simple songs	
g. create imaginary stories, fantasies, situations	
h. skip or hop on one foot 4-5 times	
i. run on tiptoes	
k. use crayons or scissors well	
l. draw a person with a head, body, arms and legs	Provider Comments
m. dress self without supervision	and the control of th
n. Does your child take a nap or rest during the day?	
o. Does he / she separate from you without difficulty?	
p. Has your child had any problems in pre-school?	
q. Has your child had any problems listening or sitting still?	
r. Do you have any concerns about development or behavior?	
s. Do you have any concerns about school readiness?	Market and Controlled to the Controlled Cont
t. Does your child use a safety seat / belt and ride in the back seat?	
u. Does anyone have a gun in the home?	
Lead Screen	
Does your child	
Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative)	Anticipatory Guidance
2. Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?	General Nutrition Injury Prevention ☐ Growth /Dev. ☐ Low fat dairy foods ☐ Car seat
3. Have a sibling or playmate who now has or did have lead poisoning?	☐ Immunizations ☐ Nutritious diet ☐ Burns / hot liquids ☐ Behavior ☐ Proper snacks ☐ Electric outlets
. i	☐ Discipline ☐ Variable appetite ☐ Never leave alone in car,☐ Sleep ☐ Pleasant mealtimes tub, house, yard
Do you have any concerns you wish to discuss?	☐ Limit television ☐ Vitamins/Fl. ☐ Poisons ☐ Dental care ☐ Limit juice ☐ Poison Center #
Parent's Signature Date	☐ Passive smoke ☐ Water safety
	☐ Ed. Handouts ☐ Sun exposure
Parent's section reviewed by	☐ Gun safety