

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

PEDIATRIC QUESTIONNAIRE AGES 12 MONTHS AND UNDER

Form Completed By _____

Birth History: (circle all that apply)

Full-term / Pre-term - if less than 37 weeks, specify # weeks gestation when delivered: _____

Vaginal / C-section - if C-section, why? _____

Birth weight: _____

Complications: _____

Nutrition:

Breast fed / Formula fed / Milk _____ (name of formula)

Amount of ounces per feeding _____

Number of hours between feedings _____

Amount of cereal and baby/table food per feeding _____; # times per day _____

Elimination: # wet diapers per day _____ Are the bowel movements normal? **Yes / No**

Stool frequency / consistency: _____

Sleep: Waking at night? **Yes / No** Number of hours sleep per 24 hour period _____

Any issues? _____

When was your last visit to the Immunizations Clinic? _____

Lead Screen (done at 6 months, 12 months)

- 1. Does your child spend time in a home or daycare built before 1950 with chipping paint? **YES / NO / UNKNOWN**
- 2. Has your child spent time in a building built before 1978 while it was being renovated? **YES / NO / UNKNOWN**
- 3. Does your child have a sibling or playmate with known lead poisoning? **YES / NO / UNKNOWN**
- 4. Does anyone in the home have a job or hobby which involves lead (e.g. refinishing furniture, loading bullets, soldering, making stained glass windows, etc.)? **YES / NO / UNKNOWN**
- 5. Does your child put dust, dirt, or paint chips in his/her mouth? **YES / NO / UNKNOWN**
- 6. Does your child live near an active lead smelter, battery recycling plant, or similar industry? **YES / NO / UNKNOWN**
- 7. Do you use folk remedies or medicines, or eat food stored in foreign-made pottery or metal containers (excluding food canned in the U.S./Canada)? **YES / NO / UNKNOWN**
- 8. Are there plastic mini blinds in your home, which are chipping or cracking? **YES / NO / UNKNOWN**

Lead risk: **HIGH:** ≥ 2 risk factors – lead level; **MODERATE:** 1 risk factor– lead level or re-screen in 6 months

Tuberculosis Screen (done at 12 months)

- 1. Has your child been in contact with anyone who has active tuberculosis? **YES / NO / UNKNOWN**
- 2. Has your child been in close contact with anyone who has been in prison (past five years)? **YES / NO / UNKNOWN**
- 3. Has your child been in close contact with anyone who has HIV infection, is homeless, lives in a nursing home, uses illegal drugs, or is a migrant farm worker? **YES / NO / UNKNOWN**
- 4. Child recently traveled to Asia, the Middle East, Africa, Eastern Europe, Latin America? **YES / NO / UNKNOWN**
- 5. Family member in close contact recently traveled to location in question above? **YES / NO / UNKNOWN**

Tuberculosis risk: **HIGH** (1 or more risk factors = YES to any question) – TB test ordered

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PATIENT'S IDENTIFICATION <i>(Use this space for Medical Imprint)</i>		
RECORDS MAINTAINED AT:		
PATIENTS NAME	SEX	
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSORS NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

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PEDIATRIC QUESTIONNAIRE AGES 12 MONTHS AND UNDER

Developmental Milestones:

Newborn - 1 Month	2 Months	4 Months
<ul style="list-style-type: none"> <input type="checkbox"/> Looks at your face <input type="checkbox"/> Follows you with his / her eyes to midline <input type="checkbox"/> Responds to sounds <input type="checkbox"/> Raises head slightly <input type="checkbox"/> Moves arms and legs equally 	<ul style="list-style-type: none"> <input type="checkbox"/> Coos <input type="checkbox"/> Smiles when you smile at him / her <input type="checkbox"/> Follows you with his / her eyes across midline <input type="checkbox"/> Holds head up when on tummy <input type="checkbox"/> Briefly holds rattle in hand 	<ul style="list-style-type: none"> <input type="checkbox"/> Initiates smile, laughs, squeals <input type="checkbox"/> Becomes active at the sight of food <input type="checkbox"/> Recognizes parent's voice <input type="checkbox"/> Good head control - steady <input type="checkbox"/> Brings hands to midline <input type="checkbox"/> Reaches and grabs <input type="checkbox"/> Rolls front to back
6 Months	9 Months	12 Months
<ul style="list-style-type: none"> <input type="checkbox"/> Repetitive vowel sounds / blows razzberries <input type="checkbox"/> Turns to voice <input type="checkbox"/> Recognizes parent <input type="checkbox"/> Self-comforts <input type="checkbox"/> Sits with support <input type="checkbox"/> Grasps and transfers objects to the other hand <input type="checkbox"/> Reaches for objects <input type="checkbox"/> Rolls over front to back and back to front <input type="checkbox"/> Bears weight on legs 	<ul style="list-style-type: none"> <input type="checkbox"/> Repetitive consonant sounds <input type="checkbox"/> Responds to name <input type="checkbox"/> Waves <input type="checkbox"/> Plays peek-a-boo/pat-a-cake <input type="checkbox"/> Sits well without support <input type="checkbox"/> Creeps/crawls/scoots <input type="checkbox"/> Inferior pincer grasp (uses more than thumb and 1 finger to pick up objects, but not entire hand) <input type="checkbox"/> Looks for covered / hidden object <input type="checkbox"/> Stranger anxiety 	<ul style="list-style-type: none"> <input type="checkbox"/> 1-4 meaningful words, as well as Dada/Mama <input type="checkbox"/> Understands simple phrases / can follow simple directions <input type="checkbox"/> Puts one object in another <input type="checkbox"/> Bangs cubes <input type="checkbox"/> Gestures/points to wants <input type="checkbox"/> Assists in feeding <input type="checkbox"/> Precise pincer grasp (picks up objects with thumb and only 1 finger) <input type="checkbox"/> Pulls to stand/cruises <input type="checkbox"/> Walks with help <input type="checkbox"/> Drinks from a cup

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