Penn Medicine | Clinical Care Associates

PEDIATRIC HEALTH ASSESSMENT SHEET

Patient Name: DOB:

In order to help us deliver quality care, we would appreciate your responses to the questions below concerning the above named individual. Please be assured that all responses are kept confidential. You should feel free to discuss any questions you have concerning these items with the doctor or nurse.

Pregnancy and Birth:

1. What was the birth weight? ____________
2. Did the baby come on time? yes no
3. Did the mother have any illnesses during the pregnancy? yes no
4. Did your baby have any trouble starting to breathe? yes no
5. Did the baby have any trouble while in the hospital? yes no

Feeding and Digestion:

1. Was there severe colic or any unusual feeding problems in the first 3 months? yes no
2. Is your child's appetite usually good? yes no
3. Is it good now? yes no
4. Do any foods disagree with him or her? yes no
5. Does he/she often have diarrhea? yes no
6. Has constipation ever been much of a problem? yes no
7. Does he/she take vitamins? yes no
8. If still on formula, what one do you use? ____________________

Family History:

1. Circle any of the following diseases that the child's parents, grandparents, aunts, uncles, brothers, sisters have had:

Tuberculosis	Diabetes	Asthma
Allergy	Seizures	Cancer
Mental Illness	Inherited Diseases	
Hepatitis	High Cholesterol	
Addictions	High Blood Pressure	

2. Are the child's parents both in good health? yes no
3. Does either parent smoke? yes no
4. Have any of the child's siblings died? yes no

5. List ages, sex and general health of the child's brothers and sisters:

____

____

____

____

Infections, Illnesses, Miscellaneous Problems and Development:

1. Has your child had as many as 3 bouts of ear trouble? yes no
2. Does he/she usually have more than 3 colds or throat infections with fever a year? yes no
3. Does he/she have trouble with urination? yes no
4. Has he/she ever had a convulsion/seizure? yes no
5. Does he/she hear well? yes no
6. Has he/she had any trouble with his/her eyes? yes no
7. At what age did he/she sit alone?
8. At what age did he/she walk?
9. Did he/she say any words by the time he/she was 1 1/2 years old? yes no
10. Does he/she have any trouble sleeping now? yes no
11. Are there any problems with his/her teeth? yes no
12. Circle any of the following that your child has had:

Measles	Whooping Cough
Pneumonia	Serious Accidents
Broken Bones	German or 3 day measles
Mumps	Removal of
Chicken Pox	tonsils and adenoids

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE!

Penn Medicine | Clinical Care Associates

PEDIATRIC HEALTH ASSESSMENT SHEET

Patient Name:

DOB:

List any other operations and give approximate date: ______________________________

____

____

List any other illnesses:

____

____

____

List any other hospitalizations and give approximate date: ______________________________

____

____

Allergies

1. Has he/she ever had eczema or hives? yes no
2. Has he/she ever had wheezing or asthma? yes no
3. Does he/she tend to have a stuffy nose or "constant cold"? yes no
4. Has he/she had any allergies or reactions to any medications or injections? yes no
   If yes, please list medications or injections and what the reaction was: ______________________________

____

____

Emotional Problems:

1. Is he/she doing well in school? yes no
2. Does he/she get along well with other children? yes no
3. Circle any of the following which your child has:

nail biting	thumbsucking	nightmares
bad temper	irritability	bed wetting
speech problems	jealousy	constipation
breath holding	behavior problems	
trouble toilet training		

Immunizations:

It is extremely important for your child's doctor to be aware of what immunizations your child has received. Please provide the doctor/nurse with a copy of your child's immunization record.

1. Is there any reason this child should not have live polio vaccine? yes no
2. Has your child had a skin test for tuberculosis? yes no
   If yes, date of last test ______________________________

Prevention:

Do you use a seat belt/car seat for your child? yes no

Does your child wear a bike helmet? yes no

Do you have a gun in the household? yes no

If yes, is it under lock and key? yes no

Do you have Ipecac in the household? yes no

Do you have the Poison Control phone number? yes no

Do you use sunscreen on your child? yes no

Do you have smoke detectors in your home? yes no

Are your matches stored out of your child's reach? yes no

Does your child live in or regularly visit a house built prior to 1960 with peeling/chipping paint or with recent renovations? yes no

Is any household member, sibling or playmate being treated for lead poisoning? yes no

Is there any household members with a job/hobby involving lead exposure? yes no

Does your child live near any facility where lead is used or released into the environment? yes no

Completed by: ______________________________ Relationship to child: ____________________ Date: ____________

Reviewed by: ______________________________ Date: ____________