

# 4 - 11 MONTH VISIT v20110614

Patient Name: \_\_\_\_\_ Sponsor SSN last four: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Contact Number: HOME \_\_\_\_\_ CELL \_\_\_\_\_

Do you have any specific concerns today? \_\_\_\_\_

Chronic Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
		<b>Allergies</b> <b>Asthma</b> <b>Other:</b>	<b>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</b> <input type="checkbox"/> Infant Multivitamin 1 ml per day

Please list any known **allergies** your child has (drug, food, latex) \_\_\_\_\_  No Allergies

Circle if anyone in the family has had: Genetic or Metabolic Disease    Kidney Disease    Deafness less than 5 years old  
 Birth Defects    Early Death or Sudden Unexplained Death of Infant or Child (to include SIDS)

Is your child enrolled in the Exceptional Family Member Program (EFMP/Q-coded)?  Yes  No

Is your child's sponsor currently deployed?  Yes  No      Is this visit **deployment** related?  Yes  No

Source of Medical Information:  Mother  Father  Other: \_\_\_\_\_

Are your child's immunizations up to date?  Yes  No  Unsure

Who does your child live with? \_\_\_\_\_

Does your child attend daycare?  Yes  No      Does anyone in the family smoke (secondhand smoke exposure)?  Yes  No

Are the instructions for the patient understood by the caregiver/patient?  Yes  No

Do you & your child feel safe at home?  Yes  No

What is your preferred method for learning:  Verbal  Written  Other: \_\_\_\_\_

Preferred language:  English  Other: \_\_\_\_\_

Are there cultural or religious considerations that affect your child's healthcare?  No  Yes \_\_\_\_\_

----- Additional Hx/Prevention -----

# weeks pregnant at delivery? \_\_\_\_\_ (Estimated gestational age)

Type of Delivery (check all that apply):  Vaginal  Forceps  Vacuum-assisted  C-section  Breech

Complications at birth? \_\_\_\_\_ Prenatal complications?  Yes  No

Group B Strep positive?  Negative  Positive (with adequate treatment)  Positive (without adequate treatment)  
 (GBS)

Born as a Single Birth?  Yes  No      Birthweight in grams: \_\_\_\_\_

Baby's hearing screen normal?  Yes  No  Not performed

Metabolic Screen?  Normal  Pending  Abnormal: \_\_\_\_\_

Breastfeeding?  Yes  No    Ounces per day: \_\_\_\_\_    Formula feeding?  Yes  No    Ounces per day: \_\_\_\_\_

Drink whole milk?  Yes  No    Ounces per day: \_\_\_\_\_    Cereal?  Yes  No  
 How many times per day? \_\_\_\_\_    Solid foods?  Yes  No    How many times per day? \_\_\_\_\_

Number of wet diapers per day? \_\_\_\_\_ **Circle** if you have concerns about: Bowel movements    Constipation    Sleep problems

Does either parent have: Little interest or pleasure in doing things? Feeling down, depressed, or hopeless?  Yes  No

Does your child have a high lead risk (based on 6 questions on wall of the exam room)?  Yes  No

**In the age group below that is closest to your child's age, please check the actions your child does:**

