

# NEW PEDIATRIC PATIENT – 1 YEAR TO 4 YEARS



Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: M F

Today's Date: \_\_\_\_\_

Please tell us the **REASON FOR TODAY'S VISIT**: \_\_\_\_\_

Please list **CURRENT MEDICATIONS**:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (ie, rash, nausea, swelling)

Are **IMMUNIZATIONS** up to date?      Yes      No      **Please provide a copy of immunization record.**

## DEVELOPMENTAL HISTORY

Please complete most current age-appropriate section for your child:

12 Months	Yes	No
Cruises		
Fills and empties containers		
Finds hidden object		
Gets to sit		
Holds cup and drinks		
Imitates words		
Pincer grasp		
Stands alone		
Turns pages		
Verbal skills: 1-2 words		
Walks alone		

15 Months	Yes	No
Climbs furniture		
Dances		
Jargon		
Rides toys		
Stands alone		
Stoops and recovers		
Throws ball		
Uses cup only		
Uses spoon		
Verbal skill: 4 words		

18 Months	Yes	No
8 or more words		
Feeds self		
Follows simple directions		
Knows 2 or more body parts		
Imitates housework		
Names pictures		
Rides toys		
Runs		
Uses spoon/fork		
Walks backward		
Walks up/down stairs		

2 Years	Yes	No
2 word sentences		
Acts worried if you are sad		
Follows 2-part verbal command		
Gets along with family		
Helps dress self		
Holds cup in one hand		
Jumps with both feet		
Kicks a ball		
Removes clothes		
Runs		
Scribbles		
Throws over hand		
Walks stairs		

For Nurse Use Only: Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

**DEVELOPMENTAL HISTORY - Continued**

Please complete most current age-appropriate section for your child:

3 Years	Yes	No
3-5 word sentences		
Asks why? Asks what?		
Balances on one foot		
Builds 10 block tower		
Copies circle and X		
Count to 3		
Dresses self		
Knows name/age/gender		
Pedals tricycle		
Plays with other kids		
Recognizes 3 colors		
Toilet trained		
Walks stairs alternating feet		

4 Years	Yes	No
4-5 word sentences		
Catches ball		
Cuts and pastes		
Draws people		
Dresses and undresses		
Enjoys jokes		
Jumps/hops		
Names 4-5 colors		
Pedals tricycle		
Plays well with others		
Walks on tiptoe		

Please provide your **PAST MEDICAL HISTORY** and **SURGICAL HISTORY** date/year if known: \_\_\_\_\_

Please provide your **FAMILY HISTORY**:

	Mother	Father	Sister	Brother	Other
ADD/ADHD					
Allergies					
Asthma					
Birth Defects					
Cancer, Type					
Coronary artery disease (heart disease)					
Deafness					
Depression					
Developmental delay					
Diabetes					
Eczema					
Genetic disorder					
Hemoglobinopathy					

	Mother	Father	Sister	Brother	Other
High cholesterol					
High blood pressure					
Hip Dysplasia					
Learning disability					
Mental retardation					
Migraines DDH					
Obesity					
Scoliosis					
Seizure disorder					
SIDS					
Strabismus (crossed eyes)					
Thyroid disease					
Other:					

Please provide your **SOCIAL HISTORY**:

Who lives with your child? \_\_\_\_\_

Tobacco Exposure	Yes	No
Are there smokers in the house?		
If yes, do they smoke outside only?		
Home Environment	Yes	No
What is the age of the home?		
Is the water chlorinated?		
Is the water fluoridated?		
Is there lead in the home?		
Education	Yes	No
Does your child go to preschool?		
Does your child have learning disabilities?		
Does your child have any special needs?		

Safety	Yes	No
Does your child use a bike helmet?		
Does your child use seat belt in car?		
Do you use a car seat?		
Is yes, which way is car seat facing?		
Do you use a booster seat in car?		
Are smoke detectors in the home?		
Is there a carbon monoxide detector?		
Are there firearms in the home?		
Are there pets in the home?		
If yes, what kind(s)?		