CHILD HEALTH HISTORY

Allergies: Home Phone#: Cell Phone #:

DATE:	NAME PARENT/GUARDIAN:	SIBLINGS:	CARETAKERS:

MEDICAL HISTORY		
Y = Yes, N = No, ? = Unknown	Patient	Family
Stroke/Hypertension	Y / N / ?	Y / N / ?
Heart Dz / Rheumatic Fever	Y / N / ?	Y / N / ?
Diabetes	Y / N / ?	Y / N / ?
Cancer	Y / N / ?	Y / N / ?
Congenital / Genetic Disorders	Y / N / ?	Y / N / ?
Blood Disorders / Sickle Cell / Rh	Y / N / ?	Y / N / ?
Lung / Tuberculosis / Asthma	Y / N / ?	Y / N / ?
Headaches / Seizures	Y / N / ?	Y / N / ?
Neuro / Mental / Emotional Heath	Y / N / ?	Y / N / ?
Breast Disease	Y / N / ?	Y / N / ?
Gall Bladder / Liver	Y / N / ?	Y / N / ?
Kidney / UTI	Y / N / ?	Y / N / ?
GI Disease	Y / N / ?	Y / N / ?
Substance Abuse	Y / N / ?	Y / N / ?
HIV	Y / N / ?	Y / N / ?
Skin / Skeletal	Y / N / ?	Y / N / ?
Thyroid / Endocrine	Y / N / ?	Y / N / ?

FOR PATIENT ONLY		
	Patient	Date
Blood Transfusion	Y / N / ?	
Blood Type:	A / B / AB / O Rh + / -	
Rubella	Y / N / ?	
Measles	Y / N / ?	
Mumps	Y / N / ?	
Hepatitis B	Y / N / ?	
STD (specify)	Y / N / ?	
Past vaccine Rxn	Y / N / ?	
Chickenpox	Y / N / ?	
Other		

Delivery History(as applicable)

Mother's Prenatal History

❑SVD

❑C/S Reason: _____

Diabetes ❑yes ❑no controlled: ❑diet ❑insulin

Hypertension ❑yes ❑no

HIV Tested ❑yes ❑no results: ❑pos(+) ❑neg(-)

PPD Tested ❑yes ❑no results: ❑pos(+) ❑neg(-)

ETOH / Tobacco / Drugs ❑yes ❑no

STD _____

RPR ❑pos (+) ❑neg (-)

HBsAg ❑pos (+) ❑neg (-)

Weeks Gestation: _____

Birth Weight: _____

APGAR: _____/_____/_____

Length: _____

Head Circ: _____

Where Delivered: _____

Hearing Screen: _____

NEONATAL PROBLEMS & CONDITIONS

❑Birth Defects _____

❑Jaundice _____

❑Feeding _____

❑Respiratory _____

❑Cardiac _____

❑Sepsis work-up results: ❑pos(+) ❑neg(-)

❑Other: _____

SERIOUS ILLNESS, ACCIDENT, HOSPITALIZATION (S):

MEDICATIONS:

FREQUENT EPISODES OF MINOR ILLNESS:

VITAMINS:

CULTURAL / ALTERNATIVE MEDCINES:

SOCIAL HISTORY

Pool: _____ Gun: _____

ETOH / Tobacco / Drugs: _____

Domestic Violence: _____ Pets:__ _____

Religion: _____ Language: _____

Family dynamics: _____

PHYSICAL HISTORY (as applicable)

Menarche: _____

Puberty: _____

Acne: _____

Sexual Activity: _____

Signature: _____

Patient Name: _____ DOB: _____ F M Language: E S Other

Childhood Lead Risk Questionnaire

KENDALL PEDIATRIC PARTNERS
11400 N. Kendall Dr., A-211
(305) 274-2255

Child's Name:	Date of Birth:

Please help us assess your child's risk for lead poisoning by answering the following questions:

		YES	NO
1.	Does your child live or regularly visit a house that was built before 1950?	☐	☐
2.	Does your child live in or regularly visit a house built before 1978 that has been remodeled in the past 6 months?	☐	☐
3.	Has your child moved to the United States within the past year?	☐	☐
4.	Does your child have a sibling or playmate with lead poisoning?	☐	☐
5.	Does your child live in or attend day care in any of the following zip codes?	☐	☐

33125 33126 33127 33128 33129 33130 33131 33140
33133 33134 33135 33136 33137 33138 33139
33141 33142 33144 33145 33147 33150 33132

6.	Does your child receive any type of public assistance (i.e., WIC, food stamps, etc.)?	☐	☐
7.	Is your child enrolled in Medicaid, or does your child receive health care in a publicly-funded clinic?	☐	☐
8.	Does your child live with an adult whose job or hobby involves exposure to lead?	☐	☐

Auto/battery repair	Painting	Fishing
Plumbing	Steel welding	Pottery work
Construction	Police/gun work	Soldering
Maritime industry	Stained glass work	Other_____

9.	Does your family use pottery or ceramics for cooking, eating, or drinking?	☐	☐

If you answered yes to any of the questions, your child's doctor will help determine if a blood lead level should be checked. If a level is checked and is found to be greater than or equal to 10 micrograms per deciliter, your child's case will be referred to the Miami-Dade County Health Department for case management.