HEALTHY KIDS CLINIC
A Part of Cumberland Family Medical Center, Inc.

Initial History Form for Well Child Exam

Only complete this form if you would like Healthy Kids Clinic to complete your student's well child exam (annual physical).

Patient Name: _____

Date of Birth: _____ Guardian Name & Number: _____

School & Grade: _____

Primary Care Physician: _____

Date of Last Well Child Exam or Sports Physical: _____

Section 1: Please mark the correct response regarding your child's health history. Please provide additional information as necessary.

Allergies: ☐ None ☐ Yes	If yes, please list all allergies and describe reactions.
Current Medications: ☐ None ☐ Yes	If yes, please list medication and dosing information.
Hospitalizations, Major injuries, Surgeries: ☐ None ☐ Yes	If Yes, please describe briefly.
Current Medical Diagnosis: ☐ None ☐ Yes	If yes, please list current diagnosis.
Living Conditions: Number of children living in home: ___	Please mark the response which accurately describes this child's living conditions. ☐ Lives with Family ☐ Lives in group/foster home ☐ Lives Alone
Has child had any of the following:	☐ Chicken Pox ☐ RSV ☐ Meningitis

Section 2: Please check any problems the patient is currently having.

General ☐ unexplained weight gain/loss ☐ poor sleep ☐ fever ☐ headache **Eyes, ears, nose, throat** ☐ wears glasses or contacts ☐ blurred vision/other visual changes ☐ mouth breathing or snoring ☐ loss of hearing or ringing in ears ☐ nasal discharge ☐ hoarseness/sore throat ☐ throat infections ☐ ear infections **Cardiovascular** ☐ chest pain ☐ heart murmur ☐ irregular heart beat/palpitations ☐ congenital heart disease **Pulmonary/lungs** ☐ shortness of breath ☐ persistent cough ☐ coughing up blood ☐ asthma or wheezing	**Neurologic** ☐ blackouts or passing out ☐ seizures ☐ headaches **Gastrointestinal** ☐ poor appetite ☐ refusal to eat ☐ abdominal pain ☐ indigestion ☐ trouble swallowing ☐ diarrhea ☐ constipation ☐ nausea or vomiting ☐ rectal bleeding or blood in bowel movement **Genitourinary** ☐ frequent or painful urination ☐ blood in urine ☐ bedwetting	**Skin** ☐ rash/itching ☐ sores that won't heal ☐ easy bruising ☐ changes in moles **Muscle/joint/bone** ☐ pain or weakness in joints/muscles **Endocrine** ☐ change in tolerance to hot or cold weather ☐ excessive thirst ☐ **NO CURRENT PROBLEMS**	**Caretaker Concerns** ☐ dietary habits _____ _____ ☐ physical development _____ _____ ☐ emotional development _____ _____ ☐ attention span _____ _____ ☐ behavior _____ _____ ☐ academics _____ _____ ☐ other concerns _____ _____ _____ _____ _____ _____

Section 3: Please circle the answer to each question. If there is space provided beside the answer, please fill in the blanks.

Nutrition: Circle foods that the patient eats every day and indicate the amount of servings per day.	Milk/Dairy:___ Meats:___ Vegetables:___ Fruits/fruit juice:___ Bread/Grains:___
Current Water Source:	City Well
Daily Exercise: How often does the patient get 30 minutes of walking, running, sports, etc.?	None 1-2 Days Per Week 2-4 Days Per Week 5-7 Days Per Week
Bowel Movements:	Everyday: Times Per Day:_____ Every 2-3 Days Every 4-6 Days
Alcohol/Drug Use:	Never used Past user Use now: Type:_____ How often:_____
Tobacco Use:	Never used Use now: Type:_____ How often:_____
Tobacco Exposure in Home:	None Exposed: In Home:_____ In Vehicle:_____
Dental Health:	Brush Regularly: Times Per Day:_____ Floss Regularly: Times Per Day:_____ Times Per Year Dentist is Visited:_____ Current Dental Issues:_____
Travel:	No travel outside US Travel outside US: Country?_____When?_____
Examine Breasts/Testicles Every Month:	No Yes
Vaccines:	Up to Date Not Up to Date/Unsure
Does child use a car seat/booster seat?	No Yes
Are there smoke detectors present in home?	No Yes
Mental Health: In past 90 days, has the child experienced any of the following?	Depression Anxiety PTSD Bipolar Other_____ None
Daily Needs:	All Daily Needs Are Met Daily Needs Are Not Met:_____
Sexually Active:	N/A No Yes: Birth Control Method: _____
Violence/Abuse/Assault: Circle which response is applicable to the child.	☐ No fear of harm ☐ Fear of verbal/physical abuse ☐ Pressure to have sex ☐Forced sexual contact ☐ Daily needs not met
How many times does child wake per night?	
How many caffeinated drinks does the child consume per day?	
How many pets are in the home?	
Girls: Menstruation	Age of first period: _____ ☐ NA

Section 4: Based upon the patient's age, mark the tasks achieved in that column.

2-3 years	4-5 years	6-7 years	8-10 years	11-15 years	16-21 years
☐ combines words ☐ names pictures and colors ☐ jumps up ☐ puts on clothing ☐ washes/dries hands ☐ names friends	☐ speaks clearly ☐ hops on one foot ☐ dresses, no help ☐ brushes teeth, no help ☐ copies others actions ☐ draws a person	☐ heel to toe steps ☐ knows alphabet ☐ counts ☐ knows right vs wrong ☐ prints letter	☐ same sex friends ☐ aware of outside world ☐ builds self confidence ☐ seeks independence ☐ peer influence	☐ seeks privacy ☐ takes some risks ☐ same sex friends ☐ different sex friends ☐ understands rules ☐ good self-image	☐ self confidence ☐ friends important ☐ less time with family ☐ thoughts of future ☐ questions rules ☐ sexual identity

By signing below, I give consent for Healthy Kids Clinic, a part of Cumberland Family Medical Center, Inc., to complete my student's well child exam. I understand this exam will take place during the 2018/2019 school year, and after the exam is complete you will receive the results from the provider.

Signature: _____ Date: _____

- **If you would like to be notified prior to the exam by letter or phone please check _____**