Name_____ Date ___/___/___

THIS SECTION TO BE COMPLETED BY PARENT

Personal Social History

Are you concerned about your child's…	YES	NO
1. feedings ☐ breast ☐ whole milk _____	☐	☐
☐ solids? _____	☐	☐
2. excessive spitting or vomiting	☐	☐
3. bowel movements	☐	☐
4. straining with stools	☐	☐
5. straining or crying with voiding	☐	☐
6. congestion or wheezing	☐	☐
If present, does this clear with sleeping?	☐	☐
7. skin color or skin rashes (circle)	☐	☐
8. excessive whining, fussing or crying	☐	☐
9. overall development	☐	☐
10. sleep habits	☐	☐
Does he/she sleep through the night?	☐	☐
If not, does he/she feed during the night?	☐	☐
Does he/she require rocking to get to sleep?	☐	☐
Does your child…		
11. screech, babble, imitate words and sounds	☐	☐
12. say 1-3 words plus "mama" and "dada"	☐	☐
13. seek attention by squealing	☐	☐
14. understand simple requests	☐	☐
15. show fear, anger, affection, jealously	☐	☐
16. become shy or anxious with strangers	☐	☐
17. finger feed using thumb and forefinger	☐	☐
18. try to turn pages in books	☐	☐
19. cooperate while dressing	☐	☐
20. walk with minimal or no assistance	☐	☐
21. creep upstairs	☐	☐
22. Do you have smoke alarms in your house?	☐	☐
23. Is your child exposed to cigarette smoke?	☐	☐
24. Is your child attending day care?	☐	☐
25. Does your child ride in a rear-facing infant safety seat?	☐	☐
26. Do you know infant CPR?	☐	☐

Lead Screen

Does your child…		
1. Live in or regularly visit a house that was built before 1950? (day care, baby sitter or relative)	☐	☐
2. Live in or regularly visit a house built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?	☐	☐
3. Have a sibling or playmate who now has or did have lead poisoning?	☐	☐
Do you have any concerns you wish to discuss?	☐	☐

_____

_____

_____

_____

_____

_____ _____

Parent's Signature Date

Parent's section reviewed by_____

History

☐ Previous concerns, consults and procedures reviewed

(Interval: ☐ No Change) Concerns_____

Current Medications _____

Drug Allergies ☐ Yes ☐ No _____

Past / Social / Family History (Interval: ☐ No Change)

Provider Comments

Anticipatory Guidance

General	*Nutrition*	*Injury Prevention*
☐ Growth /Dev.	☐ Breast	☐ Car seat
☐ Immunizations	☐ Milk	☐ Burns
☐ Behavior	☐ Table foods	☐ Smoke alarms
☐ Sleep	☐ Safe foods	☐ Electric outlets
☐ Mattress (lower)	☐ Proper snacks	☐ Infant walkers
☐ Dental care	☐ Vitamins/Fl.	☐ Poisons
☐ Passive smoke	☐ Juice	☐ Water safety
☐ TB risk		☐ Sun exposure
☐ Ed. Handouts		☐ Gun safety