Wayzata Children's Clinic

WELL VISIT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____

*Please complete the **front** of this page only. Thank you in advance for completing this form.*

LEAD EXPOSURE ASSESSMENT (complete ONLY if patient is 6 years old or younger)

Is there any concern about lead exposure for the patient?	☐ Unknown	☐ Yes	☐ No
Has the patient moved from another country or major metropolitan area in the last 12 months?	☐ Unknown	☐ Yes	☐ No
Does the patient live within the city limits of Minneapolis or St. Paul? (not including a suburb)	☐ Unknown	☐ Yes	☐ No
During the past six months, has the patient lived in or regularly visited a home, childcare facility, school, or other building built before 1950?	☐ Unknown	☐ Yes	☐ No
During the past six months, has the patient lived in or regularly visited a home, childcare facility, school, or other building built before 1978 with recent or ongoing repair, remodeling, or damage (such as water damage or chipped paint)?	☐ Unknown	☐ Yes	☐ No
Has the patient or his/her sibling, playmate, or housemate ever had a high lead level?	☐ Unknown	☐ Yes	☐ No
Does the patient receive Medical Assistance, WIC, or MN Care?	☐ Unknown	☐ Yes	☐ No

TUBERCULOSIS "TB" EXPOSURE ASSESSMENT

Does the patient have contact with anyone with tuberculosis?		☐ Yes	☐ No
Has a family member ever had a positive tuberculosis skin test (PPD, Mantoux, or Tine test)?		☐ Yes	☐ No
Is the patient or parent(s) from a country with high levels of tuberculosis?		☐ Yes	☐ No
Has the patient traveled to a country with high levels of tuberculosis, and had contact with the local people for more than one week?		☐ Yes	☐ No

SMOKE EXPOSURE ASSESSMENT

Does the patient smoke or use chewing tobacco?		☐ Yes	☐ No
Does either parent of the patient smoke?		☐ Yes	☐ No
Does the patient have regular exposure to someone who smokes, either inside or outside, or in the car?		☐ Yes	☐ No
Does the patient or other person who smokes desire information about quitting smoking?	☐ N/A	☐ Yes	☐ No

SAFETY ASSESSMENT

Are there any guns in any house where the patient lives or visits frequently?		☐ Yes	☐ No
If so, are they locked up or have safety locks, and kept out of sight?	☐ N/A	☐ Yes	☐ No
Is there any concern for the safety of the patient or exposure to violence from anyone in the household?		☐ Yes	☐ No
Is there any concern for excessive alcohol or drug use by anyone in the household?		☐ Yes	☐ No
Is there any concern for mental health problems in any of the patient's caregivers or family?		☐ Yes	☐ No

Does the patient <u>always</u> use a car seat, booster seat, or seat belt?		☐ Yes	☐ No
If under 2 years of age or under 20 pounds, does the patient use a rear-facing car seat?	☐ N/A	☐ Yes	☐ No
If under age 13, does the patient always sit in the back seat?	☐ N/A	☐ Yes	☐ No
Does the patient always use a helmet when biking, roller blading, skate boarding, riding an ATV, skiing, etc.?	☐ N/A	☐ Yes	☐ No

FLUORIDE SOURCE

Does your child have a source of fluoride? ☐ Yes ☐ No

If yes, what is the source? (city water, water at school, supplements, dental treatments, other) _____

Form completed by (print): _____ Relation to patient: _____

Signature: _____ Date: _____

Prov. Rev. _____

Thank you for completing this form.

Wayzata Children's Clinic

PATIENT HISTORY QUESTIONNAIRE

*Please complete **both sides** of the form for **each** patient cared for at this clinic.*

Patient's Name: _____ Date of birth: _____

☐ Male ☐ Female

Clinic Use Only:
If medication allergy, place allergy sticker here

MEDICATION ALLERGIES

Does the patient have any medication allergies? ☐ Yes ☐ No

MEDICATION	REACTION	AGE DIAGNOSED

BIRTH HISTORY

Was the patient adopted? ☐ Yes ☐ No

Birth weight _____

Was the patient born ☐ At term ☐ Early ☐ Late

If early, how many weeks gestation? _____

Was the delivery ☐ Vaginal ☐ Cesarean

If Cesarean, why? ☐ Breech ☐ Other, please explain

_____

Did the patient have any problems immediately after birth?

☐ Yes ☐ No If yes, explain _____

_____

_____

Did the patient's mother have any illnesses during pregnancy?

☐ Yes ☐ No Explain _____

_____

During the pregnancy, did the patient's mother:

Smoke ☐ Yes ☐ No

Take any medications ☐ Yes ☐ No

Use drugs or alcohol ☐ Yes ☐ No

What _____

_____

When _____

Did the patient's mother have any post-partum depression? ☐ Yes ☐ No

SURGICAL HISTORY

Has the patient had any surgeries or procedures? ☐ Yes ☐ No

DESCRIPTION OF SURGERY OR PROCEDURE	AGE AT TIME OF SURGERY

HOSPITALIZATION HISTORY

Has the patient been hospitalized over night (other than for the surgeries listed above)? ☐ Yes ☐ No

REASON FOR HOSPITALIZATION	AGE AT HOSPITALIZATION

Please turn this page over and complete the other side.

REORDER # 0724664

PAST MEDICAL HISTORY

Does the patient have, or has he/she ever had the following:

If yes, please explain what age diagnosed, and specific details about the type of condition.

Food allergies	☐ Yes	☐ No	_____
Environmental or nasal allergies	☐ Yes	☐ No	_____
Chicken pox (illness, not vaccine)	☐ Yes	☐ No	_____
Serious injury	☐ Yes	☐ No	_____
Eye or vision problem, or blindness	☐ Yes	☐ No	_____
Hearing problem or deafness	☐ Yes	☐ No	_____
Asthma, wheezing, or nebulizer treatment	☐ Yes	☐ No	_____
Heart problem, heart defect, heart murmur	☐ Yes	☐ No	_____
Anemia	☐ Yes	☐ No	_____
Arthritis	☐ Yes	☐ No	_____
Autoimmune disorder (lupus, etc.)	☐ Yes	☐ No	_____
Bleeding or clotting disorder	☐ Yes	☐ No	_____
Blood transfusion	☐ Yes	☐ No	_____
Bladder or kidney infection or problem	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Constipation requiring medical treatment	☐ Yes	☐ No	_____
Cystic fibrosis	☐ Yes	☐ No	_____
Eating disorder	☐ Yes	☐ No	_____
Genetic abnormality (Down Syndrome, etc.)	☐ Yes	☐ No	_____
Frequent headaches	☐ Yes	☐ No	_____
Immune problem	☐ Yes	☐ No	_____
HIV or AIDS	☐ Yes	☐ No	_____
Liver problem or hepatitis	☐ Yes	☐ No	_____
Menstrual or gynecologic problem	☐ Yes	☐ No	_____
Skin problem (eczema, etc.)	☐ Yes	☐ No	_____
Seizure	☐ Yes	☐ No	_____
Diabetes - insulin dependent (Type I)	☐ Yes	☐ No	_____
Diabetes - non-insulin dependent (Type II)	☐ Yes	☐ No	_____
Thyroid or other endocrine problem	☐ Yes	☐ No	_____
Problem with use of alcohol or drugs	☐ Yes	☐ No	_____
Psychiatric or emotional problem (depression, anxiety, etc.)	☐ Yes	☐ No	_____
Autism	☐ Yes	☐ No	_____
Learning problem	☐ Yes	☐ No	_____
ADD or ADHD	☐ Yes	☐ No	_____
Behavior problem	☐ Yes	☐ No	_____
Mental retardation	☐ Yes	☐ No	_____
Other _____			_____
Other _____			_____

Form completed by (print): _____ Relation to patient: _____

Signature: _____ Date: _____

We greatly appreciate your completing this form. It will help us to better care for your child.

Clinic Use: Provider review _____ Date _____

Wayzata Children's Clinic

FAMILY HISTORY QUESTIONNAIRE

*Please complete **both sides** of this form.*

HOUSEHOLD

Please list all children in the family / household, **including the child being seen today**

NAME	DATE OF BIRTH	CARED FOR BY WAYZATA CHILDREN'S CLINIC
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Please describe the living situation for the patient being seen today. (For example, full time with both biological parents in the same home, part time in two separate households, etc.)

_____

_____

_____

_____

Please list the type(s) of home(s) the patient lives in and the year(s) built. (Example: single family home, townhome, apartment, mobile home, etc.)

Type of home(s) _____ Year(s) built _____

Are there any pets in the home(s)? ☐ Yes ☐ No

If yes, what type(s) of pets? _____

Is any family history for the patient unknown (for example, patient is adopted)? ☐ Yes ☐ No

If yes, please describe: _____

_____

If family history is known for the patient, please turn this page over and complete the other side.

FAMILY HISTORY

Have the parents, grandparents, or siblings of the patient had any of the following:

			If yes, please explain **who**, what **age** diagnosed, and specific **details** about the type of condition.
Environmental allergies	☐ Yes	☐ No	
Food allergies	☐ Yes	☐ No	
Medication allergies	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	
Autoimmune disorder (lupus, etc.)	☐ Yes	☐ No	
Bleeding or clotting disorder	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Cystic fibrosis	☐ Yes	☐ No	
Diabetes – insulin dependent (Type I)	☐ Yes	☐ No	
Diabetes – non-insulin dependent (Type II)	☐ Yes	☐ No	
Chemical dependency (alcohol or drugs)	☐ Yes	☐ No	
Eye or vision problems or blindness	☐ Yes	☐ No	
Hearing problem or deafness	☐ Yes	☐ No	
Genetic abnormality (Down syndrome, etc.)	☐ Yes	☐ No	
Heart attack or disease before age 55	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
Cholesterol above 240 or on medication for cholesterol	☐ Yes	☐ No	
Immune problem	☐ Yes	☐ No	
HIV or AIDS	☐ Yes	☐ No	
Frequent bladder infections or bladder reflux / VUR	☐ Yes	☐ No	
Kidney disease or needing dialysis	☐ Yes	☐ No	
Liver disease or hepatitis	☐ Yes	☐ No	
Stomach or intestinal problems (reflux, GERD, ulcers, Crohn's, ulcerative colitis, etc.)	☐ Yes	☐ No	
Celiac disease or sprue	☐ Yes	☐ No	
Menstrual or gynecologic problem	☐ Yes	☐ No	
Musculoskeletal disorders (scoliosis, osteoporosis, etc.)	☐ Yes	☐ No	
Psychiatric or emotional disorder (depression, anxiety, etc.)	☐ Yes	☐ No	
Autism	☐ Yes	☐ No	
Mental retardation	☐ Yes	☐ No	
Learning problem	☐ Yes	☐ No	
ADD or ADHD	☐ Yes	☐ No	
Seizures	☐ Yes	☐ No	
Skin problem (eczema, psoriasis, etc.)	☐ Yes	☐ No	
Spina bifida	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Thyroid dysfunction	☐ Yes	☐ No	
Other _____			
Other _____			

Form completed by (print): _____ Relation to patient: _____

Signature: _____ Date: _____

We greatly appreciate your completing this form. It will help us to better care for your child.

Clinic Use: Provider review _____ Date _____