



Patient Name, #, or DOB  
or  
Attach Patient Label Here

## CHILD HEALTH RISK ASSESSMENT Birth to 11 Years

<b>25. NEWBORN HEARING SCREEN:</b> Comments:		<b>26. NEWBORN METABOLIC SCREENING</b> Sickle Cell Results _____ (Required if child is < 3 months of age)  Other Positive Results:				
Test completed <input type="checkbox"/> Yes <input type="checkbox"/> No Results (Initial test): <input type="checkbox"/> Pass <input type="checkbox"/> Fail Results (Rescreen): <input type="checkbox"/> Pass <input type="checkbox"/> Fail						
<b>27. ASTHMA TRIGGERS</b>		<b>Annual Update</b>	<b>Annual Update</b>	<b>Annual Update</b>		
a. Coughs especially at night or after exercise; exposure to cold air; cigarette smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. Allergic reactions such as food, pollen, mold, dust, animal dander, feathers, cockroaches? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
c. Chest tightness; Shortness of Breath; Wheezing? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>28. DIETARY SCREENING/ ACTIVITY SCREENING</b> Date of Visit		<b>0-1 mos.</b> Breast Formula	<b>1-3 mos.</b> Breast Formula	<b>3-6 mos.</b> Breast Formula	<b>6-10 mos.</b> Breast Formula	<b>10-15 mos.</b> Breast Formula
a. Method of feeding (circle method/s)						
b. Milk/ formula other than breastmilk or iron formula given the first year						
c. Breastfed <8 or >15 times OR <20 ounces or >40 ounces iron-fortified formula in 24 hours						
d. Has <6 wet diapers and 1 bowel movement in 24 hours						
e. Fluids other than breastmilk/ formula/ water at <4 mos.(ounces /24hrs)						
f. Iron-fortified cereal first offered at <4 months or >6 months of age						
g. Strained/ blended foods first offered at <5 months or >7 months of age						
h. Cup introduced by 7 months of age						
i. Finger/ table foods introduced by 8-9 months of age						
j. Self-feeding finger foods by 10 months of age						
k. Eats/Snacks <3 or >6 times a day by 10 months of age						
<b>Signature/Initials</b>						
<b>28. DIETARY SCREENING/ ACTIVITY SCREENING</b> Date of Visit		<b>15 – 24 mos</b>	<b>2 – 3 yrs</b>	<b>3 – 5 yrs</b>	<b>5 – 8 yrs</b>	<b>8 – 11 yrs</b>
a. Eats/Snacks <3 or >6 times a day?						
b. Eats < 6 servings of breads/ cereals/ grains daily?						
c. Drinks >3 servings of non-nutritive beverages (tea, sugar drinks, soda) daily?						
d. Eats <2 servings of dairy products daily? For >8 years of age, eats <3 servings of dairy daily?						
e. Fast foods – number meals per week						
f. Eats <5 servings of fruits and vegetables daily?						
g. Eats <2 servings of meat or meat alternative daily?						
h. Eats >2 servings of high fat foods daily (fast foods, bacon, sausage, bologna, chips, and fried foods)?						
i. Follows a therapeutic or alternative life-style diet?						
j. Routinely takes vitamin or other nutrient/ herbal supplements?						
k. Engages in prolonged, active play <5 times a week?						
l. Parent/ child concerned about feeding/ eating/ diet/ weight?						
<b>Signature/Initials</b>						

## CHILD BASIC HISTORY (DHHS 2811)

1. –6. NAME, NUMBER, ETC. In the blank space in the top left on the front, attach the computer generated label or emboss the information imprinted on the patient's identification card or manually record the patient's name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YY), race, gender, and county of residence.
7. ENGLISH SPEAKING Check "Yes" or "No" as appropriate. If "No", record the language spoken.
8. INTERPRETER Check "Yes" or "No" as appropriate. If "Yes", record who is providing interpretation.
9. ALLERGIES List all patient's allergies: food, drugs, insects, environment. Record in red ink if possible.
10. DATE Record the date the initial history is taken.
11. SOURCE OF INFORMATION Check "Parent" when information is provided by the parent. Check "Other" when someone else is the informant. Specify name and relationship to the patient. Indicate when both parent and other person contributed significantly.
12. MOTHER'S NAME Record mother's full name.
13. MOTHER'S DATE OF BIRTH Record mother's date of birth or age.
14. FAMILY HISTORY Indicate by "X" presence of any of these problems in patient or close relative(s). Indicate by "O" the absence of any of these problems in this same group. Detail positive findings. Information recorded on previously completed history forms may be referenced here. Update at subsequent well care visits. At the time of the update, if no new findings are found, enter date and sign.  
**Family history is to be updated annually with any positive findings noted.**
15. PREGNANCIES Count the mother's pregnancies up to and including the one with this child. Do not include pregnancies after this child was born.
16. PRENATAL CARE Record month prenatal care began during pregnancy with this child. Record the number of visits. Record site of care.

## DHHS 2811 (cont)

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| 17. | MATERNAL PROBLEMS  | Indicate by "X" in box, those problems experienced by mother while pregnant with this child. Indicate by "O" the absence of any of these problems in this same group while pregnant with this child. Record significant details about problems in the available space. |
| 18. | MATERNAL DRUG USE  | Indicate by "X" those used by mother while pregnant with this child. Record kind and amount as accurately as possible. Detail positive findings.   |
| 19. | BIRTH HISTORY  | Record number of weeks gestation. Record birth weight. Record where infant was delivered and the APGAR score if known.   |
| 20. | TYPE OF DELIVERY   | Note delivery method and significant problems.   |
| 21. | NEONATAL PROBLEMS  | Indicate with "X" applicable neonatal problems. Record significant problems. Detail positive findings.   |
| 22. | INFECTIOUS DISEASES  | Indicate with "X" the appropriate block to indicate having had the disease. Indicate with "O" the appropriate block to indicate not having had the disease. <b>Update annually, noting any positive findings.</b>  |
| 23. | CHRONIC OR SERIOUS ILLNESS, INJURY, HOSPITALIZATION/ SURGERY | Record diagnosis, condition or operation; date of occurrence and outcome. Detail when possible, whom and where care was given. <b>Update annually, noting any positive findings.</b>   |
| 24. | SIGNATURE/DATE   | Record full legal signature of health professional responsible for this information.   |

## Child Health Risk Assessment Birth to 11 Years

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|-----|---------------------------------------|---|
| 25. | NEWBORN HEARING SCREEN                | Indicate "Yes" or "No" as appropriate. Record results and rescreen results if applicable. Note significant details. |
| 26. | NEWBORN METABOLIC SCREENING           | Record results as indicated.  |
| 27. | ASTHMA TRIGGERS                       | Check "Yes" or "No" as appropriate. <b>Update annually.</b>   |
| 28. | DIETARY SCREENING/ ACTIVITY SCREENING | Record findings as noted for specific age group. <b>Update annually.</b>  |
- SIGNATURE OR INITIALS –Record legal signature of health professional obtaining information.