Pediatric Health History
Ages 0-12 years

Child's name: ____________________________
First Middle Initial Last

Sex: ☐ Male ☐ Female Date of birth __________ / __________ / __________

Parent/Guardian: ____________________________
First Middle Initial Last

Phone: __________________________________________

Birthplace
Hospital: __________________________________________
City __________________________ State: __________________________

Prenatal
Did you receive prenatal care? ☐ No ☐ Yes
What month of pregnancy did you start your prenatal care? __________________________
Who did you see for prenatal care? __________________________________________
Who delivered your baby? __________________________________________
Did you attend prenatal classes? ☐ No ☐ Yes

Mother's Health During Pregnancy
Please indicate any of the following that were problems for you during your pregnancy.

☐ Vaginal bleeding ☐ Headaches
☐ Weight ☐ High blood pressure
☐ Swelling of the feet or ankles ☐ Gestational diabetes
☐ Other: __________________________________________

Did you consume alcohol during your pregnancy? ☐ No ☐ Yes, amount __________ frequency __________
Did you smoke during your pregnancy? ☐ No ☐ Yes, amount __________
Did you take any prescription or over-the-counter drugs during your pregnancy? ☐ No ☐ Yes
Did you use any illegal drugs during your pregnancy? ☐ No ☐ Yes

Labor/Delivery
Gestational age at time of delivery? ____________ weeks
Was your labor induced? ☐ No ☐ Yes How long were you in labor for? ____________
Type of birth: ☐ Vaginal ☐ C-section Were forceps used? ☐ No ☐ Yes
Baby's weight at birth: ____________ Length: ____________ Apgar (if known): ____________
Any complications at birth? ☐ No ☐ Yes, explain: __________________________________________
Please indicate any of the following complications that your baby had after delivery.

☐ Seizure ☐ Jaundice ☐ Infection ☐ Vomiting
☐ Congenital abnormalities ☐ Difficulty breathing ☐ Difficulty sucking ☐ Cyanosis
☐ Other: __________________________________________

How long did the baby stay in the hospital after delivery? ____________
Did the baby have to be in a special nursery? ☐ No ☐ Yes
Was the baby circumcised? ☐ No ☐ Yes ☐ N/A Physician: __________________________
**Child's History**

List any medical problems your child currently has and when they started:

________________________________________________________________________

If your child is being treated for any illness or medical problems by another health care provider, describe the problem and indicate who is treating your child:

________________________________________________________________________

Has your child had any surgeries/procedures or been hospitalized?  □ No  □ Yes, please list below:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Reason</th>
<th>Date</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immunizations**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Nutrition:**

Please indicate the type of feeding your child receives/received.

□ Breast Frequency: ____________ Duration: ____________

□ Bottle Frequency: ____________ Amount: _______ ounces  Type of formula: ____________

Does your child currently take vitamins:  □ No  □ Yes, name and dose: ___________________________

Is your child on solid foods:  □ No  □ Yes

Age when cereal started: ____________ Age when vegetable started: ____________

Age when juices started: ____________ Age when meats started: ____________

Age when fruits started: ____________ Age when eggs started: ____________

Please indicate any of the following that your child currently has or has had in the past.

□ Crossed or wandering eyes  □ Anemia  □ Measles
□ Recurring ear infection  □ Chronic/frequent diarrhea  □ Rubella (3 day measles)
□ Ear tubes  □ Recurrent vomiting  □ Mumps
□ Speech problems  □ Bed wetting  □ Polio
□ Hearing loss  □ Scoliosis  □ Kawasaki's disease
□ Frequent colds  □ Pain in arms, legs, joints  □ Scarlet fever
□ Genetic disorders  □ Swelling in arms, legs, joints  □ Colic
□ Asthma  □ Headaches  □ Jaundice
□ Hay fever  □ Seizures  □ Rheumatic fever
□ Pneumonia  □ Whooping cough  □ Other, please list: __________________________
□ Heart murmur  □ Chicken pox
Does your child have any of the following allergies:
- [ ] No allergies
- [ ] Medications, list: ____________________________
- [ ] Food, list: ____________________________
- [ ] Other, list: ____________________________

Development 0-5 years of age
Current age of your child:
How old was your child when he/she started doing the following?
- Rolled over by self: ____________________
- Stood alone: ____________________
- Caught a ball: ____________________
- Sat by self: ____________________
- Walked by self: ____________________
- Talking: ____________________
- Crawled: ____________________
- Fed self: ____________________
- Toilet trained: ____________________

If the section below does not apply to your child at this time, skip to the next section. If this section does apply to your child, please indicate the date on the line below the date that you are completing this information.

Development 6-18 years of age
Date this section is being completed: ____________________
Current age of your child: ____________________
How old was your child when he/she started school? ____________________ years
What grade is your child in? ____________________ grade
Does your child have any hearing problems? [ ] No [ ] Yes
Does your child have any vision (eye) problems? [ ] No [ ] Yes
How does your child learn best? [ ] Written materials [ ] Audio (listening) [ ] Visual (pictures)
Does your child have any learning disabilities? [ ] No [ ] Yes, explain: ____________________

Social History
Does your child have any kind of problems relating to his/her peers? [ ] No [ ] Yes [ ] N/A
Who does your child live with? [ ] Both parents [ ] Mother [ ] Father [ ] Other
Number of people living in your home: ____________________
Are your living conditions appropriate/sufficient? [ ] No [ ] Yes
Is your child’s primary language English? [ ] No, list primary language: ____________________ [ ] Yes
As the parent/guardian of this child, is English your primary language? [ ] No, list: ____________________ [ ] Yes
How do you prefer information for teaching/instructions?
- [ ] Written materials [ ] Audio (listening) [ ] Visual (pictures) [ ] Any of those listed

Family History
Mother’s name: ____________________ Age: _________ Occupation: ____________________
Father’s name: ____________________ Age: _________ Occupation: ____________________
Marital status: [ ] Never married [ ] Married [ ] Divorced [ ] Separated [ ] Widowed
Living arrangements of parents: [ ] Living together [ ] Living apart
Family History (continued)
Please indicate any of the following that a member of your family currently has or has had in the past.

- Birth defects
- Cancer
- Hay fever
- Thyroid problems
- Obesity
- Alcoholism
- Hepatitis
- Arthritis
- DES exposure
- Diabetes
- Asthma
- Psychiatric disorder
- Mental retardation
- Cystic fibrosis
- High blood pressure
- Sexually transmitted disease
- Headaches
- Anemia
- Heart disease
- Allergies
- Epilepsy
- Stroke

Safety/Housing Concerns
Do you have smoke detectors in your home?  □ No  □ Yes
Do you have carbon monoxide detectors in your home?  □ No  □ Yes
Does anyone smoke in your home?  □ No  □ Yes
Do you have any nutritional concerns?  □ No  □ Yes
Does your child drink dairy/milk?  □ No  □ Yes (1-3 cups daily)  □ Yes (3-6 cups daily)
Does your child have access to unlocked cupboards containing harmful substances?  □ No  □ Yes
Does your child have a car/booster seat that is age appropriate?  □ No  □ Yes  □ N/A
Are you concerned about any type of abuse in your home?  □ No  □ Yes
Do you have any pets?  □ No  □ Yes

What type of home do you live in?  □ House  □ Apartment  □ Mobile home
Do you own or rent your current home?  □ Own  □ Rent
How old is your home? ____________________________ years
Number of bedrooms: ____________________________ Number of bathrooms: __________
Water source:  □ Well  □ City well  □ Other
Heat source:  □ Gas  □ Oil  □ Other

Thank you for taking the time to complete this form. The information you provide will be helpful in planning your child's health care.

Signature of person completing this form: ____________________________________________________________
Relationship to the patient: ___________________________________________________________ Date:______ / ______ / ______
Adolescent Health History
Ages 13-18 years

Date: ______________________

Name: _______________________________ Age: _____ Birthdate: _______________

Sex: □ Male □ Female Grade in School: ______________ Religion: ______________

Reason for visit: __________________________________________________________________________

Current Health Status: □ Excellent □ Good □ Fair □ Poor Date of Last Physical: ______________

Please place a mark in the box next to any of the following that you have:

□ Hearing problems □ Difficulty seeing □ Difficulty reading □ Other disabilities

If "other" is marked please list: ______________________________________________________________________

How do you prefer to learn? □ Written/visual material □ Verbal teaching

Is your primary language English □ Yes □ No If no, please list: ________________________________

Have you ever had any surgeries: □ Yes □ No If yes, please list: ________________________________

Medical History: (check if you currently have or have had in the past)

□ Chest pain □ Allergies/Hayfever □ Nosebleeds
□ Depression □ Weight loss □ Sinus Problems
□ Excessive hunger □ Constipation □ Blood in Urine
□ Excessive thirst □ Diarrhea □ Painful Urination
□ Earache □ Nausea □ Persistent Cough
□ Ear Drainage □ Vomiting □ Irregular/rapid heart beat
□ Fainting □ Shortness of Breath □ Vision Problems
□ Headache □ Rash

Check any of the following illnesses you have or have had:

□ Measles □ Diphtheria □ Cancer
□ Mumps □ Pertussis (whooping cough) □ Diabetes
□ Rubella □ Aids □ Epilepsy
□ Roseola □ Alcoholism □ Heart Disease/Murmur
□ Chicken Pox □ Anemia □ Venereal Disease
□ Scarlet Fever □ Anorexia □ Hepatitis
□ Rheumatic Fever □ Asthma
□ Polio

Other: __________________________________________
Males Only:
Do you have pain in your testicles?  □ Yes  □ No
Do you do self testicular exams?  □ Yes  □ No
Do you have a discharge from your penis?  □ Yes  □ No
Do you have a sore on your penis?  □ Yes  □ No

Females Only:
At what age did your period start ______________________
How often is your period __________________________ How many days does your period last ______________________
Do you experience pain with your periods?  □ Yes  □ No
Have you ever been pregnant?  □ Yes  □ No
Do you do self breast exams?  □ Yes  □ No

Prenatal History:
Where were you born: ___________________________ Were you premature: ______________________________________
Did you have any complications or problems at birth?  □ Yes  □ No
If yes what were they? ________________________________________________________________
Did your mother smoke, or use alcohol and/or drugs during pregnancy?  □ Yes  □ No
If yes, what was it? ______________________________________________________________

Hospitalizations/Surgeries/Injuries:
List all including date, where, and why, and any outpatient procedures
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Current Medications:
Name __________________ Dosage __________________ When Prescribed __________________
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
Do you take any over the counter medications?  □ Yes  □ No (If yes please list)

Allergies:
Medications: ____________________________
Foods: ____________________________
Other: ____________________________
Ever been tested for allergies:  □ Yes  □ No  If yes when __________ Results __________

Ossio Pediatrics, PLLC
Immunizations: (list date of last or “X” if never received)

MMR: ____________________________
DPT: ____________________________
Polio: ____________________________
HIB: ____________________________
Flu: ____________________________

Tetanus Booster: ____________________________
Pneumonia: ____________________________
TB Test: ___________ results: ____________________________
Hepatitis B: ________ titer results: ____________________________

Self Care/Health habits: (the following includes questions regarding current health habits, sexuality and use of drugs and alcohol, please answer honestly, all information is considered confidential and will not be shared with anyone other than your healthcare provider without your permission)

1. Are you often sad or depressed?  □ Yes □ No
2. Are you often nervous or tense?  □ Yes □ No
3. Do you feel something is wrong with your weight?  □ Yes □ No
4. Have you ever thought of killing yourself?  □ Yes □ No
5. Have you ever been in trouble at school?  □ Yes □ No
6. Have you ever been in trouble with the police?  □ Yes □ No
7. Is there violence or abuse in your home:  □ Yes □ No
8. Have you ever been touched in a way that made you feel uncomfortable?  □ Yes □ No
9. Have you ever been physically, emotionally or sexually abused?  □ Yes □ No
10. Do you have a boyfriend or girlfriend?  □ Yes □ No
11. Have you been or are you currently sexually active?  □ Yes □ No
12. Do you use birth control?  □ Yes □ No
13. What type of birth control do you use? (check all that apply)
   □ Birth control pills
   □ Condoms
   □ Depoprovera
   □ Diaphragm
   □ Spermicidal gels/foam
   □ Withdrawal
   □ Nothing
   □ Other: ____________________________
14. Please check any of the following substance you are currently using or have used in the past?
   □ Cigarettes
   □ Cocaine/Crack
   □ Chewing tobacco/Snuff
   □ Glue/Aerosol Cans
   □ Marijuana
   □ LSD/PCP/Peyote
   □ Steroids
   □ Beer/Wine
   □ Amphetamines/Speed
   □ Liquor such as whiskey, vodka etc.

Any other drugs or alcoholic beverages you use or have used: ____________________________

15. Do you feel that you have a problem with drugs or alcohol?  □ Yes □ No
16. Do you feel anyone in your family has a problem with alcohol or drug use?  □ Yes □ No
17. Has anyone ever told you that you have problem with drugs or alcohol?  □ Yes □ No
18. Do you have any questions regarding sex, sexuality, birth control, alcohol or drug use or any other questions regarding your health?  □ Yes □ No
Family History: check if your blood relatives have had any of the following

- Arthritis
- Asthma
- Cancer
- Diabetes
- Heart Disease
- Hypertension
- Tuberculosis
- Glaucoma
- Epilepsy
- Kidney Disease
- Thyroid Disease
- Stroke
- Mental Illness
- Chemical Dependency

Thank you for taking the time to complete this form. The information you provided will be helpful in planning your health care.

Person completing form: __________________________ Relationship if not patient: __________________________
NEW PATIENT INFORMATION SHEET
PLEASE COMPLETE ALL SECTIONS AND RETURN TO RECEPTIONIST

PATIENT
(First) ____________________________ (Last) ____________________________ (Middle Initial) ____________________________

DATE OF BIRTH ____________________________

PHONE (_____) ____________________________ CITY ____________________________

PT'S SOCIAL SECURITY NUMBER ____________________________ PT GENDER: MALE / FEMALE

PARENT/LEGAL GUARDIAN (Mom) ____________________________ (Dad) ____________________________

PARENT/LEGAL GUARDIAN'S EMPLOYER (Mom) ____________________________ (Dad) ____________________________

PRIM INS ____________________________ SECOND INS ____________________________

SUBSCRIBER NAME ____________________________ SUBSCRIBER'S DATE OF BIRTH ____________________________

SUBSCRIBER'S SOC SEC # ____________________________ SUBSCRIBER'S SOC SEC # ____________________________

RLNSHIP TO SUBSCRIBER ____________________________ RLNSHIP TO SUBSCRIBER ____________________________

GROUP # ____________________________ GROUP # ____________________________

CONTRACT # ____________________________

PERSON TO CONTACT IN CASE OF EMERGENCY/PHONE ____________________________

(Not living at same address as first contact)

ALTERNATE EMERGENCY CONTACT/PHONE ____________________________

DRUG ALLERGIES ____________________________

________________________

Lossio Pediatrics, PLLC participates with a variety of health care plans including Medicaid, Molina Medicaid, most Michigan BCBS Plans, Blue Care Network, ConnectCare, Aetna, Cofinity, Health Care Alliance Pool, The Chandler Group, McLaren Commercial and Medicaid; MidMichigan Health Plan, CIGNA, Priority Health, HealthPlus, Midland Health Plan, Central Health Plan, Physicians Health Plan, and TriCare/Tricare Prime. Participation means that we have a contract with these insurance companies and must accept their “allowable” fee as payment in full. Deductibles, co-pays and non-covered services are not included. If we do not participate with your insurance carrier, you may still have a balance after your insurance company has paid. If your insurance plan is not listed, please check with your insurance carrier and/or your employer to find out participation prior to receiving any services. Participation is subject to change. As a courtesy to our patients, Lossio Pediatrics, PLLC submits claims to all carriers, regardless of your participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day service is rendered, or for paying in full if we do not participate with your health care plan.

I understand that my insurance policy is a contract between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time services are rendered. I agree to be financially responsible for all costs incurred by my dependent child in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by this office, whether conducted in this office or elsewhere, which are not otherwise paid by my insurance.

I hereby authorize Lossio Pediatrics, PLLC or its designees to bill and release to my insurance company and/or third party payor(s) and/or external review agency(s) such information contained in my child's patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information.

________________________

Signature: ____________________________ Date: ____________________________

(LEGAL PARENT OR GUARDIAN)
RELEASE OF INFORMATION CONSENT

At times we receive requests by our patients and their family members regarding the patient's health status and other health management information (lab results, test results, medication refills or changes, etc.)

To protect your patient confidentiality, we ask your permission to release this information to individuals you specify below. If you are unavailable or become incapacitated, which individuals do you approve our release of information to?

Please take time to fill out this form with the requested information. If an individual you have indicated requests information about you or for you, we will ask their address and phone number to be sure they are the one you designated. If you do not have all the information with you, please take this form home with you for completion and return it to us at your convenience.

NAME(S) OF PERSON(S) YOU AUTHORIZE US TO RELEASE INFORMATION TO:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, ________________________, give ____________________________ permission to release medical information (health status report, lab or test results, medication refill or medication changes) regarding my treatment and ongoing health care needs to the persons(s) I have indicated above.

Witness Signature

Patient Signature

Date

Date

Providers will share patient information with other providers who are involved in the patient's care, as appropriate. The data sharing may be through written medical information or through electronic sharing of information.
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the NOTICE OF PRIVACY PRACTICES of LOSSIO PEDIATRICS, PLLC on the date indicated below.

Signature: ___________________________ Date: _________________

Patient: ___________________________

Information about Agent (attach appropriate documentation):

Agent: ___________________________

Title: ___________________________

FOR OFFICE USE ONLY

☐ Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

☐ Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

☐ Other ___________________________

Signature: ___________________________ Date: _________________

Print Name: _________________________
Lossio Pediatrics, PLLC

Release of Information Authorization

I authorize the use or disclosure of the below named individual's health information as described in this document.

The following Individual or Organization is authorized to make the disclosure: ________________________________

The type of Information to be used or disclosed:  Consultation Reports  EKG's  X-Ray Reports

Laboratory Reports  Discharge Summaries  Emergency Records  Operative Reports

History&Physicals  Pathology Reports  Entire Record

I understand that the information in my Health Record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following: Lossio Pediatrics, PLLC

245 Warwick Dr., Ste D Alma, MI 48801

Self  Other ________________________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ________________________________

If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months from date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to assure treatment. I understand that I may inspect a copy of the the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization.

Patient Name: ________________________________  DOB: ________  Phone: ________________________________

Mailing Address: ________________________________  City: ________  State: ________  Zip: ________

Patient/Parent Signature: ________________________________  Date: ________________________________

Staff Signature: ________________________________
# Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer “yes” to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the child sick today?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Does the child have allergies to medications, food, a vaccine component, or latex?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has the child had a serious reaction to a vaccine in the past?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. If your child is a baby, have you ever been told he or she has had intussusception?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn’s disease, or psoriasis; or had radiation treatments?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Has the child received vaccinations in the past 4 weeks?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FORM COMPLETED BY:** __________________________  **DATE:** __________

**FORM REVIEWED BY:** __________________________  **DATE:** __________

Did you bring your immunization record card with you?  [ ] Yes  [ ] No

It is important to have a personal record of your child’s vaccinations. If you don’t have one, ask the child’s healthcare provider to give you one with all your child’s vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.