If you are completing forms by hand, please use a PEN with BLUE or BLACK ink. Thank you.

University of Iowa Stead Family Children's Hospital

Center for Disabilities and Development

PARENT FORM

Center for Disabilities and Development

Initial Medical History

Patient's Legal Name: ____
first name *middle initial* *last name*

Patient's Date of Birth:_____________________ Patient's Gender: male ☐ female☐

Patient's Address: ____

Form completed by:____Date: ______________________

Your Relationship to Patient:

- ☐ parent
- ☐ step parent
- ☐ guardian (please send guardianship papers)
- ☐ foster parent
- ☐ other (please specify:___________________)

Patient lives with:

- ☐ birth parents
- ☐ adoptive parents
- ☐ foster parents
- ☐ single parent
- ☐ parent and step parent
- ☐ other relatives
- ☐ group home
- ☐ other (please specify:___________________)

Parent's Name: ________________________________

Parent's Date of Birth: ___________________________

Place of Employment: ____________________________

Occupation: _________________________________

Phone 1: ____________________________________

Phone 2: ____________________________________

E-Mail Address: _______________________________

Home Address, if different from patient's:

____

____

Parent's Name: ________________________________

Parent's Date of Birth:___________________________

Place of Employment: ____________________________

Occupation: _________________________________

Phone 1: ____________________________________

Phone 2: ____________________________________

E-Mail Address: _______________________________

Home Address, if different from patient's:

____

____

CURRENT CONCERNS

What concerns do you have currently? (Please check all that apply.)

- ☐ Concerned that my child has autism.
- ☐ Concerned that my child has ADHD.
- ☐ Concerned about my child's behavior.
- ☐ Concerned that my child is not developing properly.
- ☐ School problems or learning concerns.
- ☐ Sleep problems.

Comments:____

SAFETY

We strive to provide a safe environment for our patients here at CDD. You can help us to provide this safe environment by answering the following question.

Does your child have a history of aggressive behavior to self or others?
(ie: hitting, kicking, biting, choking, scratching) Yes/No

If yes, please explain the behaviors and what triggers it:
____
____
____
____
____
____

Please call our Nursing Line at 1-877-686-0031 (Option #3) if there is something else you would like to share with us about your child's behaviors.

BIRTH HISTORY

Patient's birth weight: __________________

Where was the patient born? ____
hospital name *city, state*

The patient was born: ☐ at term ☐ early ☐ late

If early, how many weeks' gestation? _____________

The delivery was: ☐ vaginal ☐ caesarean

If caesarean, why? ____

Did mother have any problems with her pregnancy? ☐ yes ☐ no

If "yes," please explain: ____

During pregnancy, did mother:

Smoke? ☐ yes ☐ no

Drink alcohol? ☐ yes ☐ no

Use drugs or medicine? ☐ yes ☐ no

If "yes," what and when? ________________________________

Did the patient have problems right after birth? ☐ yes ☐ no

If "yes," please explain: ________________________________

Did the patient go home from the hospital with mother? ☐ yes ☐ no

If "no," please explain: ________________________________

Did the patient pass a newborn hearing test? ☐ yes ☐ no

If "no," please explain what follow-up steps were taken: ________________________________

____

MILESTONES

At what age did the patient begin to sit alone? _____________

At what age did the patient begin to crawl? _____________

At what age did the patient begin to walk? _____________

At what age did the patient say his/her first words? _____________

At what age did the patient begin to put words together? _____________

MEDICAL HISTORY

Do you consider the patient to be in good health? ☐ yes ☐ no

Has the patient had any of the following? (If "yes," please check the box.)

- □ serious injuries or accidents, including head injury
- □ surgeries
- □ hospitalizations
- □ allergy to medications or foods
- □ chicken pox
- □ dental problems
- □ frequent ear infections
- □ problems with hearing
- □ nasal allergies
- □ chronic snoring
- □ problems with eyes or vision
- □ asthma, bronchitis or pneumonia
- □ heart problem or heart murmur
- □ anemia or bleeding problems
- □ blood transfusion
- □ feeding or growth problems
- □ constipation
- □ bladder or kidney problems
- □ chronic or recurrent skin problems
- □ muscle or bone problems
- □ frequent headaches
- □ seizures or other neurological problems
- □ sleep problems
- □ diabetes
- □ thyroid or other endocrine problems
- □ exposure to lead
- □ swallowing difficulties
- □ speech or communication problem

If you checked any of the boxes above, please explain here, and include dates:____________________________________

____

____

____

Does the patient have any trouble using his/her hands, arms or legs? □ yes □ no

Does the patient use any special equipment? □ yes □ no

If so, please explain here:____

____

Does the patient have any serious illness or medical problems not listed? □ yes □ no

If so, please explain here:____

Local physician's name and address:

____

Does the patient see any other care providers/physicians? □ yes □ no

*If "yes," please list:*____

____

Is the patient up to date on immunizations? □ yes □ no

If "no," please explain: ____

Does the patient smoke, or use alcohol or drugs? □ yes □ no

If "yes," please explain: ____

How many hours per day does the patient spend watching TV /videos, or playing video /computer games? ____________

Does the patient have any sensory issues? □ yes □ no

If yes, please describe. ____

Has the patient seen a dentist in the last year? □ yes □ no

Are there any concerns regarding the patient's dental health? □ yes □ no

If "yes," please explain: ____

Would you like to schedule a free dental screening for the patient at the CDD? □ yes □ no

Has the patient had a hearing test in the past year? □ yes □ no

In cases of speech delay or behavior problems, we need to know if hearing is normal to make accurate diagnosis and appropriate recommendations. Would you like to add a hearing test to your visit? □ yes □ no

Do you or your doctor have concerns about:

Fast weight gain? □ yes □ no

Slow weight gain? □ yes □ no

Is the patient on a special diet? □ yes □ no

If "yes," please explain: ____

Does the patient have limited food preferences? □ yes □ no

Is the patient receiving gastrostomy or NG tube feedings? □ yes □ no

Is the patient drinking nutritional supplements like Pediasure? □ yes □ no

Do you have concerns about your child's overall nutritional status? □ yes □ no

MEDICATIONS

Please list all medications the patient currently takes:

Medication Name	Dosage	Schedule	Prescribed By	Reason for Taking

SCHOOL INFORMATION

Name and address of patient's school, preschool or daycare:

____

What grade is the patient in?________________

Do you have concerns about the patient's current school program? ☐ yes ☐ no

If "yes," please explain: ____

Has the patient had testing or evaluations done at school or an agency? ☐ yes ☐ no

If "yes," please provide the school or agency name and address: ______________________________

____

Does the patient have, use, or participate in any of the following? (Please check all that apply.)

- ☐ aide, associate or paraeducator
- ☐ reading support
- ☐ behavior plan
- ☐ physical therapy
- ☐ special education program
- ☐ AEA (Area Education Agency)
- ☐ social services/DHS (food stamps, medical coverage, respite care, FIP)
- ☐ social services/DHS (Child Welfare Unit)
- ☐ WIC
- ☐ IEP (Individualized Education Program)
- ☐ resource room
- ☐ counseling
- ☐ speech therapy
- ☐ occupational therapy
- ☐ waiver services
- ☐ SSI (Supplemental Security Income)
- ☐ visiting nurse
- ☐ vocational rehabilitation

FAMILY AND SOCIAL HISTORY

Please provide information about the patient's family members:

Name	Relationship to Patient	Age	Health Problems	Education	Occupation

Has the patient or family had any recent changes or stress? ☐ yes ☐ no

If "yes," please explain: ____

Are there any concerns about abuse? ☐ yes ☐ no

*If "yes," please explain:*____

Have any of the patient’s family members had any of the following?

If "yes," please tell us which family member (grandmother, uncle, etc.) and on which side of the family (maternal = mother's side, paternal = father's side.)

Learning Difficulty □ yes □ no

If “yes,” which family member?

Speech Disorder □ yes □ no

If “yes,” which family member?

Autism Spectrum Disorders □ yes □ no

If “yes,” which family member?

Intellectual Disability □ yes □ no

If “yes,” which family member?

Attention Deficit/Hyperactivity Disord □ yes □ no

If “yes,” which family member?

Seizures □ yes □ no

If “yes,” which family member?

Depression or Other Mental Illness □ yes □ no

If “yes,” which family member?

Drug Abuse □ yes □ no

If “yes,” which family member?

Hearing Problems □ yes □ no

If “yes,” which family member?

Asthma □ yes □ no

If “yes,” which family member?

Heart Disease (before age 50) □ yes □ no

If “yes,” which family member?

Heart Disease (after age 50) □ yes □ no

If “yes,” which family member?

Anemia □ yes □ no

If “yes,” which family member?

Diabetes (before age 50) □ yes □ no

If “yes,” which family member?

Any additional information that you think would be helpful for us to know before your visit:

Your signature: ____ Date: ______________________

Please return completed forms to us to move forward with scheduling your child's appointment.

By mail:
Center for Disabilities and Development
100 Hawkins Drive
Iowa City, IA 52242-1011

By e-mail:
cddpre-service@healthcare.uiowa.edu

By fax:
319-384-9393