MEDICAL REPORT ON CHILD

(To be completed by the Paediatrician/Medical Practitioner)

1. Particulars of Child

Name: ……

Sex: …… Date of Birth: …… Age:……..

Father's Name/ Guardian's name: ……

Address: ……

……

Hospital of Birth: ……

Diagnoses: ……

Karyotype: ☐Non Disjunction ☐Translocation ☐Mosaic Date: ……..

Details: ……

2. Neonatal History

Gestation: …… Mode of Delivery……

Birth Weight: ……kg Length: ……..cm OFC (HC): ……cm

APGARs: 1 min.: …… 5 min.: ……..

Cry after birth: ☐ Immediate ☐ After Stimulation ☐ After Resuscitation (give details)

Summary of the neonatal period:

……

……

……

……

Informed Parents and counselled after birth: ☐ Yes ☐ No

When was information given: ……

3. Feeding History

Reason for NOT breastfeeding:

☐ Medical ☐ Parents' preference ☐ Others: ……..

A. Breastfeeding: ☐ Yes ☐ No ☐ Exclusive Breast feeds

Duration of Feed: ……min

Frequency of Feeds: every …….. Hours

ENQUIRE

During Breast Feeding:

☐ Breathlessness while feeding

☐ Coughing spells while feeding

☐ Choking spells while feeding

☐ Cyanotic spells

(These symptoms are suggestive of uncoordinated Suck-Swallow-Breathing)

B. Formula Feeds: : ☐Yes ☐No

If Yes:

Mode of Feeding: ☐Bottle Feeding ☐Spoon ☐Small cup

Type of Formula:…….. Frequency of feeds: ……

Volume of feeds: …… Total formula feeds in 24 hours: …….

C. Tube Feeding: ☐Yes ☐No

If yes, give details:

……

……

Feeding issues, if any/ other details:

……

(*Remarks for KDSF office use*)

……

4. History of Gastro-esophageal reflux (GER)

Regurgitation	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Acute life threatening episodes	☐ Yes	☐ No
Persistent projectile vomiting (rule out surgical causes)	☐ Yes	☐ No

Bowel Habits

☐Age appropriate regular habits ☐Constipated

If constipated, details and management advised:

……

Feeding / Dietary advice given:

……

5. History of recurrent respiratory infection: (Aspiration/ Atopy/ Cardiac causes)

……

……

6. Physical Examination

General condition: ……

Nutrition:……

Weight: ……..percentile Height: ……..percentile OFC/HC: ……

Heart rate: ……/min RR: ……/min

☐ Anaemia ☐Cyanosis ☐Icterus

☐ Lymphadenopathy If yes, details: ……

Skin: ……

Vision: ……

Red Reflex: ☐Yes ☐No (to rule out cataract)

ENT: ……

☐ Others: ……

7. Systemic Evaluation

(*Remarks for KDSF office use*)

Cardiovascular: ……
Respiratory: ……..
Abdomen: ……
Neurological: ……..
Muskulo-Skeletal: ……

8. Developmental Assessment: Time Line

Milestones	Time line
A. Social smile	…….. months
B. Head control	…….. months
C. Roll over	…….. months
D. Sit without support	…….. months
E. Creep on all 4's	…….. months
F. Walk without support	…….. months
G. Speech and language	
Cooing	…….. months
Babbling	…….. months
Single words	…….. months
H. Independence	
Feeding	☐ Yes ☐ No ☐ With Help
Dressing	☐ Yes ☐ No ☐ With Help
Mobility	☐ Yes ☐ No ☐ With Help
Toilet trained	☐ Yes ☐ No ☐ With Help

9. Hearing Evaluation (*hearing evaluation should be completed by 6 months of age*)

Hearing evaluation done: Yes☐ No ☐ Date: ……

OAE at birth (DD : MM : YY)

R: ☐PASS / ☐FAIL/ ☐REFER L: ☐PASS / ☐FAIL/ ☐REFER

(REFER= Repeat test AEBR)

AEBR (DD : MM : YY)

……..

Hearing Loss:

R: ☐None ☐ Mild ☐ Moderate ☐Moderately Severe ☐Severe ☐Profound

L: ☐None ☐ Mild ☐Moderate ☐Moderately Severe ☐Severe ☐ Profound

(Mild: 20-40 dB; Moderate: 41-55 dB; Moderately severe: 56-70dB; Severe: 71-90dB; Profound: 91or more)

Sensori-neural hearing loss:

☐Yes ☐No

Conductive hearing loss:

☐Yes ☐No

10. Health

A. Immunization (Updated copy must be given to KDSF for filing)

BCG …….

Hepatitis …….

DPT …….

Poliomyelitis ……

HiB …….

MMR …….

Boosters ……

B. Past Illness

Meningitis ……..

Encephalitis ……

High Fever ……..

Coma ……..

11. Allergies

☐ Yes ☐ No If Yes, please state: ……

Medication/Restriction, if any: ……

12. Special Diet

☐ Vegetarian ☐ Gluten-free ☐ Casein-free ☐ Lactose-free

☐ Others…….

13. Fits

☐ Yes ☐ No If Yes, Type of fits: ……

Medication, if any: ……..

14. Hyperkinesis

☐ Yes ☐ No

Medication, if any: ……..

15. Family History (If Yes, specify type)

Consanguinity	☐ Yes	☐ No	……
Fits	☐ Yes	☐ No	……
Mental Retardation	☐ Yes	☐ No	……

16. Psychological Assessment (If Yes, attach report)

☐ Yes ☐ No

17. Referral/ Specialist Consult

A.	Physiotherapist	☐ Yes	☐ No
B.	Occupational Therapist	☐ Yes	☐ No
C.	Speech Therapist	☐ Yes	☐ No
D.	Audiologist	☐ Yes	☐ No
E.	Opthalmologist/Optometrist	☐ Yes	☐ No
F.	Others ……		

…….. ……

Signature and Stamp of Doctor-in-charge Date