Program Year _____ **Early Childhood/Head Start** Site _____

H E A L T H H I S T O R Y

Child's Name _____ DOB _____

Pregnancy/Birth History and Family Health History

Birth Weight? _____lbs. _____oz. Was child born more than 3 weeks early or late? NO / YES Was the child premature? NO YES

If premature, how many weeks? _____ Was anything wrong with child at birth? NO YES What_____

Is mother pregnant now? NO YES Did mother have any health problems during pregnancy? NO YES What _____

Please "check" if the child's parents, grandparents, aunts, uncles, brothers, sisters, or cousins had any of the following:
__Diabetes __Birth Defects __Sickle Cell __ Allergies __Tuberculosis __ Anemia __Vision Loss
__Convulsions __Asthma __Cancer/Leukemia __Kidney Disorder __Cerebral Palsy __ Substance Abuse __ Hearing Loss

____ Any other disease or condition not mentioned above? What _____

Medical History

Name of Medical Provider _____ Date of Last visit _____

Has your child had an unfavorable experience at a medical or dental office? NO YES Please explain _____

Has child been hospitalized or had surgery? NO YES Hospital _____ Age _____ Reason _____

Has child had any broken bones, head injuries, burns or poisoning? NO YES Please explain _____

Does your child have an allergy? NO YES Is allergy documented by a physician? NO YES Check allergy(s) and list the irritants

___ FOOD ALLERGY: _____ What symptoms show?_____

___ ENVIRONMENTAL: _____ What symptoms show?_____

___ MEDICATION: _____ What symptoms show?_____

Is your child currently or has your child ever seen a specialist? NO YES Where? _____ Why? _____

Any evaluation such as, Psychological, Speech, Neurological NO YES What? _____ Where? _____

Does child have a vision problem? NO YES Describe (wears glasses, eye patch, cross-eyed, etc.) _____

Does child have a hearing problem? NO YES P.E. Tubes? NO YES

Has your child ever been abused? NO YES Please explain _____

Is your child taking any medications now? NO YES Please list, and explain why: _____

Will child need to be given any medication during the day while at preschool? NO YES Medication: _____

Has child ever had any of the following diseases or conditions? Please indicate Yes or No for each item.

	YES	NO
DIABETES		
CONVULSIONS/SEIZURES		
CANCER/LEUKEMIA		
CYSTIC FIBROSIS		
SICKLE CELL DISEASE (People with traits say "Yes")		
HEART CONDITION/HEART MURMER		
TRAUMATIC BRAIN or HEAD INJURY		
CEREBRAL PALSY		
ASTHMA		
PNEUMONIA		
HEPATITIS		
MUMPS		
MEASLES		
RUBELLA (German Measles)		
CHICKEN POX		
WHOOPING COUGH		

	YES	NO
RESPIRATORY DISEASE		
TUBERCULOSIS		
LEAD POISONING		
ANEMIA OR LOW BLOOD		
BLOOD DISORDERS		
AUTISM		
NEUROLOGICAL DISORDER		
BLADDER or KIDNEY DISORDER		
ECZEMA		
FREQUENT NOSEBLEEDS		
FREQUENCY IN URINATION		
FREQUENT COLDS		
FREQUENT EYE INFECTIONS		
FREQUENT EAR INFECTIONS		
FREQUENT HEADACHES		
OTHER		

If "Yes" to any condition or disease listed, please explain: _____

White Copy - Child's File
Yellow Copy – Parent Copy

Program Year _____ **H E A L T H H I S T O R Y** Site _____

Child's Name _____ DOB _____

Dental History

Please CIRCLE any that applies to your child:

easy bruising bleeding gums thumb sucking finger sucking lip sucking nail biting lip biting toothache recently

prolonged bleeding when cut. Has child ever been to the Dentist:? YES ___ NO ____

Name of Dental Provider _____ Date of Last visit _____

Diet/Nutrition History

Does child have any dietary restrictions? NO YES Please list _____

Are there foods your child is not allowed to eat due to religious reasons? NO YES Please list _____

Does child have difficulty chewing? NO YES swallowing? NO YES Need adaptive equipment to eat? Specify _____

Do you feel your child's height and weight are normal for his/her age? NO YES Did child ever have a problem with weight? NO YES

Does child take a vitamin/mineral supplement/herbal supplement? NO YES Does child have an outside area to play? NO YES

Is child physically active every day? NO YES Have you noticed any change in your child's bowel movement? NO YES

Do you eat with your child at meal time? NO YES Do you add salt at the table? NO YES, add sugar at the table? NO YES

Does child eat meals in ___kitchen ___living room ___ while watching TV ___ Other? Please explain _____

What are your child's favorite foods? _____ Foods your child dislikes? _____

About how often does your child eat a food item from each of the following groups, according to the food guide pyramid?

	Serv. Size (3-5 yrs)	Approximate number of times per **DAY**						
(a) Milk, cheese, yogurt, soy milk	6 oz.	0	1	2	3	More		
(b) Meat, poultry, fish, eggs, dried beans, peanut butter	1.5 oz.	0	1	2	3	More		
(c) Oranges, grapefruit, bananas, grapes, peaches, juices	1/4 cup	0	1	2	3	4	More	
(d) Greens, carrots, cabbage, corn, potatoes, broccoli	1/4 cup	0	1	2	3	4	5	More
(e) Bread, cereal, grits, cornbread, rice, pasta	1/2 slice or 1/3 cup	0-4	5-8	9-11	More			
(f) Kool-Aid, donuts, candy, cookies	(Per package)	0	1	2	3	More		

Developmental/Social/Psychological History

Could child sit up at 9 months? NO YES Walk unassisted by 15 months? NO YES Say understandable words by 18 months? NO YES

Does child drink from(Circle) Cup Bottle Both Eat with: Fingers Spoon/Fork Both Dress without assistance? NO YES

Could child put words together in a sentence by 3 years? NO YES Does child follow one-step directions? NO YES

What activities does your child enjoy or do especially well? _____

How does your child tell you that he/she has to use the toilet? _____

Other Information: Which of the following characteristics describe your child? Please indicate Yes or No for each item.

	Yes	No		Yes	No		Yes	No
does child talk			sleep problems			frequent tantrums		
short attention span (0-2 min.)			listens to a story and/or music			has frequent minor illnesses		
is extremely overactive			knows own name (not nickname)			recurrent vomiting		
prefers to be alone			takes a nap			has severe headaches		
clings to parent			injures self frequently			nervous or easily excitable		
is shy			injures others			starts fires		
plays with other children			destroys property			has difficulty learning		
eats non edible things (dirt, paper, paint chips)			can crawl, walk, hop, jump, skip, run			repeats words that you say, rather than answer question		

Which of the above characteristic(s) that you marked "Yes" concern you? _____

Is there anything else we should know about your child? _____

This information is collected for educational planning purposes **only.**

_____ _____

PARENT/GUARDIAN SIGNATURE DATE STAFF SIGNATURE DATE

White Copy - Child's File Yellow Copy – Parent Copy