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HEALTH HISTORY

Child's Name_____ Birth Date_____ Age_____

A. PRENATAL HISTORY

1. Was mother's age (under 17 or over 35) at time of birth: _____ Yes _____ No.
2. Did mother gain (under 20 lbs. or over 40 lbs.) during pregnancy? _____ Yes _____ No.
3. Did you have prenatal care? _____ Yes _____ No
   If yes, what month of pregnancy did prenatal care begin? _____
4. Were there any health problems/complications/injuries during your pregnancy? Yes _____ No _____
   If yes, explain _____
5. Were there any complications/problems during labor or de livery for the mother or the child?
   Yes ____ No ____ If yes, explain _____
6. Birth weight _____lbs. _____ozs.
7. Was your child full term? ____Yes ____No If no, number of weeks _____

B. HEALTH

1. Did your child have any medical illnesses at birth or within the first year? Yes _____ No _____
   If yes, explain _____
2. Has your child had a serious accident in the past? ____Yes ____No Head injury? ____Yes ____ No
   If yes, explain _____
3. Does your child seem well most of the time? ____Yes ____No
4. Has your child ever had any serious health problems? _____Yes _____No
   If yes, explain _____
5. Does your child have health problems now? ____Yes ____No
   If yes, explain _____
6. Is your child regularly taking any medication (ex. aspirin, laxatives, vitamins, etc.)? _____Yes _____No
   If yes, what medication? _____ Why? _____
7. In a year, has your child had as many as three (3) ear infections? _____Yes _____No
8. Are you concerned about your child's hearing? _____Yes _____No
9. In a year, does your child have more than 3 colds or sore throat infections with a fever? ___Yes ___No
10. Are you concerned about your child's eyes or vision? ____Yes ____ No
11. Has your child ever been seen by a medical specialist? ____Yes ____No
    If yes, explain _____
12. Does your child have any special needs? _____Yes _____No
    If yes, explain _____
13. Has your child ever been hospitalized? ____Yes ____No
    If yes, explain _____
14. Is your child allergic to any foods or substances? ____Yes ____No
    If yes, to what? _____ (Ask for Food Allergy Action Plan form).
15. Please note any birth marks or Mongolian spots:_____

C. TOILETING

1. Is your child potty trained? ____Yes ____No
   If yes, at what age? _____ If no, at what age would you like to start? _____
2. What word does your child use for: urination? _____ bowel movement? _____
3. What is the frequency of your child's bowel movements? _____

D. DEVELOPMENTAL HISTORY

1. How do you comfort your child? _____
2. What are your child's favorite toys? _____
3. What are your child's favorite activities? _____
4. What are you encouraging at home to expand your child's interests? _____
5. Can your child:
   - Feed himself/herself using a spoon and/or a fork? ____Yes ____ No
   - Wash and dry his/her own hands? ____Yes ____No
   - Help with dressing or dress with little assistance? ____Yes ____No
   - Speak so that he or she can be understood by others? ____Yes ____No
   - Express his or her thoughts and needs easily? ____Yes ____No
6. Do you have any concerns about your child's appetite or willingness to try different foods?
   If yes explain: _____
7. Has your child ever had trouble walking, climbing, reaching, or holding on to things? ____Yes ____No
   If yes explain: _____

E. SLEEPING AND EATING HABITS

1. Do you have any special ways of helping your child go to sleep? _____Yes _____ No
   How? _____
2. Does your child cry when going to sleep? ____ Yes ____ No
3. What is your child's current sleeping schedule?
   Night time: From _____ to _____
   AM nap: From _____ to _____
   PM nap: From _____ to _____
4. Does your child use a pacifier at home? _____ Yes _____ No
   Please note: at school, only Infants and Toddlers may use pacifiers – Toddlers at nap time only.
5. Does your child have a special blanket? ____ Yes ____ No
6. What is your child's present eating habit? Choose one phrase to describe each meal below:
   - **Not Hungry**
   - **Eats Well**
   - **Eats A Lot**

   Breakfast _____
   Lunch _____
   Snack _____
   Dinner _____
7. Has your child had any eating problems? ___ Yes ___ No If yes, explain

<u>Infant Program</u>:

1. Was your baby breastfed? ____ Yes ____ No
2. Is baby still breast feeding? ____Yes ____No
3. Type of formula: _____

Are there any other things you would like to tell us about your child?

_____
_____
_____
_____

PLEASE SIGN AND RETURN TO THE OFFICE with a <u>copy of your child's birth certificate</u>.

_____ _____ _____

Print Parent Name Parent's Signature Date