

HEALTH HISTORY



Child's Name _____

Date of Birth _____

Birth Weight _____

Birth History:

During your pregnancy with this child, did you:

Experience any illness?

Yes _____ No _____

If yes, please explain: _____

Take any medications?

Yes _____ No _____

Have any problems with labor or delivery?

Yes _____ No _____

If yes, please explain: _____

Did the child have problems after birth?

Yes _____ No _____

If yes, please explain: _____

Did the child stay in the nursery longer than 2 days?

Yes _____ No _____

Child's Medical History:

Has your child had any recurrent illnesses?

Yes _____ No _____

Has your child stayed overnight in a hospital?

Yes _____ No _____

Has your child had any serious illnesses?

Yes _____ No _____

Is your child taking any medications regularly?

Yes _____ No _____

If so, please list: _____

Has your child ever had:

A reaction to medication?

Yes _____ No _____

If so, please list _____

Anemia

Yes _____ No _____

Allergies

Yes _____ No _____

Asthma

Yes _____ No _____

Seizures or fits

Yes _____ No _____

Eye Problems

Yes _____ No _____

Frequent Ear Infections

Yes _____ No _____

Kidney or Bladder Infections

Yes _____ No _____

Heart problems

Yes _____ No _____

Muscle problems

Yes _____ No _____

Digestion or Stomach problems

Yes _____ No _____

Skin problems

Yes _____ No _____

Surgery

Yes _____ No _____

If so, please list _____

Serious accidents

Yes _____ No _____

Child lives with: Mother _____ Father _____ Both _____ Relatives _____ Other _____

Does the child regularly attend daycare? Yes _____ No _____

Does anyone in the house smoke? Yes _____ No _____

Was your home built before 1980 or is the child a frequent visitor in a home built before 1980? Yes _____ No _____

Does your child have contact with a child with lead poisoning? Yes _____ No _____

Do you live near a lead processing facility, hazardous waste site, or within sight of an interstate highway? Yes _____ No _____

Does any member of the household engage in a lead-related occupation or hobby? Yes _____ No _____

Family History:

List any immediate family members who have the following problems?

Asthma _____

Seizures _____

Allergies _____

Sickle Cell _____

Anemia _____

Tuberculosis _____

Diabetes _____

Birth Defects _____

Heart Attack at less than 50 years old _____

High Cholesterol _____

Mental/Emotional Difficulties _____

Development:

Do you have any concerns about your child's behavior? Yes _____ No _____

If yes, please explain: _____

Ages 5 and Older:

Does your child get along well in school? Yes _____ No _____

Does your child get along well with other children? Yes _____ No _____

Does your child have any problems learning? Yes _____ No _____

Parent Signature _____ Date _____