HEALTH HISTORY FORM – to be completed by parent(s)

Child's Name _____ Date completed: _____

A. HEALTH

1. Does this child seem well most of the time? Yes _____ No ____
2. In a year, has your child had as many as three episodes of ear trouble? Yes _____ No ____
3. In a year, does this child usually have more than 3 colds or sore throat infections with a fever? Yes _____ No ____
4. Does this child have trouble getting rid of severe coughs? Yes _____ No ____
5. Does this child complain frequently of headache, leg ache, stomach aches, or other pain? Yes _____ No ____
6. Has this child had trouble with his/her eyes or vision? Yes _____ No ____
7. Is this child's appetite usually good? Yes _____ No ____
8. Does this child chew unusual things such as pencils, cribs, window ledges, paint chips, plaster or hair? Yes _____ No ____
9. Does this child have any difficulty sleeping? Yes _____ No ____
10. When was he/she last seen by a dentist? _____
11. Was all the dental work he suggested completed? Yes _____ No ____
12. Was this child seen by a doctor since last clinic examination? Yes _____ No ____
    If so, when? _____ What for? _____
13. Is this child taking any medication now? Yes _____ No ____
    If so, what? _____
    Why? _____
14. PAST HISTORY – Circle any of the following that your child has ever had:

"red' or "hard" measles	premature birth
german or 13-day measles	trouble breathing at birth
Mumps	Birth injury or defect
Chicken pox	Head injury
Meningitis	Allergies (Eczema, hives, drugs, hay fever)
Scarlet fever	Food intolerance
Kidney or bladder infection	Asthma/wheezing
Diabetes	Convulsions, seizures, fits
Pneumonia	Heart trouble

    High fever (above 104 degrees 3 days or more)

15. RECENT HISTORY – Circle any the child has had recently:

Frequent urination	Dizziness, fainting spells
Small stream or dribbling	Tires easily
Burning or painful urination	Swollen glands
Constant cold	Shortness of breath
Bowel problems	Difficulty hearing
Bleeds easily	Joint pain

16. Other illnesses or diseases? Yes _____ No ____
    If yes, what? _____
17. Has your child been hospitalized? Yes _____ No ____

If yes, when? _____

For what? _____

18. Has this child had any serious accidents or ingestions? Yes _____ No ____

If yes, when, what type and how treated? _____

_____

19. Does this child have any physical restrictions? Yes _____ No ____

20. Has this child ever been seen by a medical specialist? Yes _____ No ____

If yes, when, by whom and for what? _____

_____

21. Has this child ever had a Sickle Cell test? Yes _____ No ____

If yes, when? _____

B. GROWTH AND DEVELOPMENT

1. Does this child get along well with family members? Yes _____ No ____

If not, briefly describe _____

_____

2. Are you concerned about your child in any of the following areas? If so, briefly explain.

a. bedwetting _____

b. wetting during the day _____

c. difficulty going to bed or staying in bed _____

d. bad dreams, wakefulness, disturbed sleep _____

e. thumbsucking _____

f. biting nails, nervous habits _____

g. stammering or stuttering _____

h. irritability, easily upset, feelings hurt easily _____

i. restlessness, overactivity _____

j. day dreaming, mind not on what he's doing _____

k. overly cautious, fearful, shy _____

l. wanting too much attention, comfort or support; clingy _____

m. breath holding _____

n. contrary, stubborn, uncooperative, disobedient _____

o. selfishness, inability to share _____

p. jealousy _____

q. anger, temper tantrums _____

r. destroying things on purpose _____

s. clumsiness, awkwardness _____

t. too much concern about sex for age _____

Other comments: _____

_____

3. What experiences has this child had with groups? (daycare, pre-school, headstart, church, temple, etc)

4. Other information about your child that will be helpful. _____

_____

Parent's signature: _____