CHILD 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____

Social/Environmental History:

Child lives with : Mother____Father____Both____Relatives____Foster____

Does the child regularly spend time in 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____