HEALTH HISTORY - TO BE COMPLETED BY PARENTS.

Child's Name____________________________DOB_____Health Date_____

A. HEALTH

1. Does this child seem well most of the time? Yes__No__
2. In a year, has this child had as many as 3 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? Yes__No__
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? Date_________
    What for?
13. Is this child taking any medication now? (For example, aspiring, laxatives, etc?) Yes__No__
    If yes, what medication?____________________
    Why?____
14. PAST HISTORY - Circle any of the following this child has ever had:
    - "Red" or "Hard" measles
    - German or 13-day measles
    - Mumps
    - Chicken pox
    - Meningitis
    - Scarlet Fever
    - Kidney or bladder infection
    - Diabetes
    - Pneumonia
    - High Fever (above 104 degrees for 3 days or more)
    - Premature birth
    - Trouble breathing at birth
    - Birth injury or defect
    - Head Injury
    - Allergies, (Eczema, hives, drugs, or food intolerance, hay fever, wheezing, or asthma)
    - Convulsions, seizures, fits
    - Heart trouble
15. RECENT HISTORY - Circle any the child has had recently:
    - Frequent urination
    - Small stream or dribbling
    - Burning or painful urination
    - Constant cold
    - Bowel problems
    - Bleeds easily
    - Dizziness, fainting spells
    - Tires easily
    - Swollen glands
    - Shortness of breath
    - Difficulty hearing
    - Joint pain

6. Other illnesses or diseases? Yes__No__

If yes, what?

7. Has this child been hospitalized? Yes__No__
If yes, for what?

8. Has this child had any serious accidents or ingestions? Yes__No__
If yes, list type, when, how treated______________________________
____

9. Does this child have any physical restrictions? Yes__No__

10. Has this child ever been seen by a medical specialist? Yes__No__

11. Has this child ever had a Sickle Cell test? Yes__No__
If yes, When?__________________

GROWTH AND DEVELOPMENT

1. **Does this child get along well with all family members? Yes__**
   If not, with whom?______________________________
   Comments____
2. **Are you concerned about your child in any of the following areas:**
   - **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; clinging?**
   - **m. Breath holding**
   - **n. Contray, stubborn, uncooperative, disobedient?**
   - **o. Selfishness, inability to share?**
   - **p. Jealously?**
   - **q. Anger, temper tantrums?**
   - **r. Destroying things on purpose?**
   - **s. Clumsiness, awkwardness?**
   - **t. Too much concern about sex for age?**

Comments____

3. **What experiences has this child had with groups? (Day Care, Pre-school, Head Start, church or Temple school?_________________**
   ____
4. **Is there anything additional that you would like to tell us about your child?____**

Parents's Signature____________________________Date_____________