Health History for Preschool and School Age

Summit Early Learning Center, Inc.
Minneapolis, MN 55405
Phone: 612-377-9011 Fax: 612-977-0168

Child's Name ____ Birth Date: ______________

Section A: Health History

1. Does this child seem well most of the time? Yes No

2. Is child taking any medications now (including aspirin, laxatives, vitamins, etc.)? Yes No
   If yes, what? _________________________ Why? _________________________

3. In the last year, has this child had as many as three (3) ear infections? Yes No

4. In the last year, has this child had more than three (3) colds or sore throat infections with a fever? Yes No

5. Does this child have trouble getting over severe coughs? Yes No

6. Does this child complain frequently of headache, leg ache, stomachache, or other pain? Yes No

7. Is this child's appetite usually good? Yes No
   If no, explain ____

8. When was he/she last seen by a dentist? Date: ____________________ Yes No
   If less than six months, circle "No"

9. Has this child been seen by a doctor since his/her last well check-up? Yes No
   If yes, when? _________________ What for? ____

10. Does your child have any handicaps/special needs? Yes No
    If yes, please describe: ____

11. Other illnesses or diseases? Yes No
    If yes, what? ____

12. Has this child been hospitalized? Yes No
    Describe: ____

13. Has this child had any serious accidents or poisonings? Yes No
    Describe: ____

14. Does this child chew unusual things like pencils, chalk, cribs, window ledges,
    paint chips, plaster or hair? Yes No

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Section A: Health History Continued

15. **Past History** – Select any of the following illnesses/conditions your child has ever had:

"Red" or "hard" measles	Kidney or bladder infection	Birth injury or defect
German or 13-day measles	Diabetes	Head injury
Mumps	Pneumonia	Chickenpox
Meningitis	Premature birth	Convulsions, seizures, fits
Scarlet Fever	Trouble breathing at birth	Heart trouble

High fever (above 104° for 3 days or more)
Allergies (Eczema, hives, drug or food intolerance, hay fever, wheezing or asthma)

16. **Recent History** – Select any symptoms the child has had recently:

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

17. Does this child have any physical restrictions? Yes No
If yes, what? ____

18. Has this child ever had a sickle cell test? If yes, when ___________________ Yes No

Section B: Growth and Developmental History

1. Does this child get along with:

Mother	Yes No
Father	Yes No
Brother(s)	Yes No
Sister(s)	Yes No
Other children	Yes No

Comments: ____

2. Are you concerned about any of the following: (select any that apply)

Bedwetting	Wetting during the day	Difficulty going to bed	Bad dreams/wakefulness/disturbed sleep
Nail-biting	Thumb sucking	Stammering/stuttering	Irritability/easily upset/feelings easily hurt
Restless/over-active	Overly cautious/shy/fearful	Breath holding	Daydreaming/distracted/difficulty focusing
Selfishness/inability to share	Anger/temper tantrums	Wanting too much attention/comfort/support; clingy	
Jealousy	Destroys things on purpose	clumsiness	Overly concerned with sex for his/her age

3. What experiences has this child had with groups (day care, preschool, Head Start, church or temple school)?

____

Parent's Signature ____ Today's Date _______________