CHILD'S HEALTH HISTORY

Child's Name: D.O.B.: Reviewed by CFS: Date:

PREGNANCY/BIRTH FAMILY HISTORY	Yes	No	Don't Know	Explain
Did mother have any health problems during pregnancy or delivery?	☐	☐	☐	
Did mother visit a physician regularly during pregnancy?	☐	☐	☐	
Was child born more than 3 weeks early or late?	☐	☐	☐	
What was child's birth weight?				
Were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc. after your baby's birth?	☐	☐	☐	
Did child or mother stay in hospital longer than usual?	☐	☐	☐	
Is mother pregnant now?	☐	☐	☐	
Has your child been involved with DAC (Developmental Assessment Clinic), Early On or Early Head Start? Check any that apply.	☐ DAC	☐ Early On	☐ Early Head Start	
Has your family been involved in an Individual Family Service Plan?	☐	☐	☐	

HOSPITALIZATION AND ILLNESS	Yes	No	Don't Know	Explain
Has child ever been hospitalized or operated on? If "Yes", please explain.	☐	☐	☐	
Has child ever had a serious accident or illness? If "Yes", please explain (broken bones, head injuries, falls, burns, poisoning).	☐	☐	☐	

HEALTH/SAFETY	Yes	No	Don't Know	Explain
Does child have frequent ear infection, sore throat, cough, urinary infections or trouble urinating, stomach pain, vomiting, diarrhea? Circle all that apply.	☐	☐	☐	
Does child have difficulty seeing? (Squint, cross eyes, look closely at books?)	☐	☐	☐	
Is child wearing (or supposed to wear) glasses?	☐	☐	☐	
Does child have problems with ears/hearing? (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear?)	☐	☐	☐	
Can others understand your child when she/he talks?	☐	☐	☐	
Is your child in long term medical treatment? Diagnosis/Medication: _____ Physician: _____	☐	☐	☐	
Has child had: Asthma, Bleeding Tendencies, Diabetes, Epilepsy, Heart/Blood Vessel Disease, Liver Disease, Rheumatic Fever, Sickle Cell Disease, low iron or Anemia? Circle all that apply.	☐	☐	☐	

Diagnosed allergies: Reaction:
Diagnosed by: Medication:

CHILD HEALTH STATUS AND CARE HSPPS 1302.42

does your child have a regular Dr.? ☐ yes ☐ no
If yes, list name of Dr. and office:
Does your child currently have medical insurance? ☐ yes ☐ no
If yes, list insurance type:

Does your child have a regular dentist? ☐ yes ☐ no
If yes, list name of dentist and office:
Does your child currently have dental insurance? ☐ yes ☐ no
If yes, list insurance type:

Exposure to Lead HSPPS 1302.46

Does your child now or in recent past live in or visit a house built before 1950 with chipping or peeling paint?

☐ Yes ☐ No

Does your child now or in recent past live in or visit a house built before 1978 that has been remodeled in the last year?

☐ Yes ☐ No

Does your child live with an adult whose job or hobby involves lead?

☐ Yes ☐ No

Does your child have a brother, sister, or playmate with lead poisoning?

☐ Yes ☐ No

Tobacco Use/Smoking HSPPS 1302.46

Are all people living in the child's home nonsmokers?

☐ Yes ☐ No

Does anyone living in the child's home use electronic cigarettes or chewing tobacco?

☐ Yes ☐ No

Is the child exposed to second hand smoke?

☐ Yes ☐ No

NUTRITION QUESTIONS HSPPS 1302.42, 1302.46

List the following
Foods your child likes:

Foods your child dislikes (if any):

Does your child often have a problem with any of these?

☐ Diarrhea ☐ Being too heavy ☐ being too small
☐ Constipation ☐ Being too thin

Who does most of the cooking in your home?

Do you typically

☐ Cook from SCRATCH ☐ use CONVENIENCE foods?

How does your child feel about meal times?

☐ Enjoys ☐ Not interested ☐ Needs encouragement

How would you describe your child's appetite?

☐ Good ☐ Average ☐ Picky ☐ Poor

How many time a day does your child eat SNACKS?

☐ None ☐ 1-2 times ☐ 3-4 times ☐ 5-6 times ☐ throughout the day

How many times a day does your child drink JUICE?

☐ none ☐ 1-2 time ☐ 3-4 times ☐ 5-6 times ☐ throughout the day

Does your child drink from a bottle? ☐ Yes ☐ No

If yes, what usually?

If you give a bottle, how much formula or breastmilk does your baby USUALLY take at one feeding?

Does your child take a bottle to bed? (Check)

☐ Usually ☐ Sometimes ☐ Never

Did you, or do you currently, breastfeed this baby? Yes No Currently

If yes, are you having any concerns or problems with breastfeeding?

Explain:

If you give your baby breastmilk or formula in a bottle, how do you heat it up?

	Yes	No	Explain
Does your child take vitamin/mineral supplements? Do they contain iron? ☐ yes ☐ no Do they contain fluoride? ☐ yes ☐ no Were they prescribed? ☐ yes ☐ no			
Is there any food(s) your child should not eat for medical, religious, or personal reasons? If so, provide an explanation	☐	☐	
Is your child on a special diet? (Diabetic, Vegetarian, allergies etc).	☐	☐	
Do you have concerns about what your child eats or has there been a recent change in appetite?	☐	☐	
Does your child feed him/herself ?	☐	☐	
Does your child chew or eat things that are not food?	☐	☐	
Does your child have trouble chewing or swallowing?	☐	☐	

If your child is receiving any regular milk, what kind is it? check one.

☐ None ☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Soy ☐ Goat ☐ Other

Please list any concerns or challenges you are having with your child that we could support you with:

Parent /Guardian/Foster Signature: Date:

Parent/Guardian/Foster Recertification: Date: