# 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?<br>Do they contain iron? ☐ yes ☐ no<br>Do they contain fluoride? ☐ yes ☐ no<br>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: