

HEALTH HISTORY – INFANTS / TODDLERS

(To be completed by parent before admission)

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

A. HEALTH

1. Does this child seem WELL most of the time? Yes \_\_\_\_ No \_\_\_\_

2. Is child taking any MEDICATIONS at this time? Yes \_\_\_\_ No \_\_\_\_

If Yes, What medications? \_\_\_\_\_

Why? \_\_\_\_\_

3. In a year, has this child had as many as 3 episodes of EAR TROUBLE? Yes \_\_\_\_ No \_\_\_\_

4. Are you concerned about your child's HEARING? Yes \_\_\_\_ No \_\_\_\_

5. In a year, does this child usually have more than 3 COLDS or SORE THROAT infections with a fever? Yes \_\_\_\_ No \_\_\_\_

6. Has this child had trouble with his/her EYES or VISION? Yes \_\_\_\_ No \_\_\_\_

7. Has a MEDICAL SPECIALIST ever seen this child? Yes \_\_\_\_ No \_\_\_\_

If Yes, Who? \_\_\_\_\_

Why? \_\_\_\_\_

8. What arrangements have you made for the care of your child should he or she become ILL at the Center?  
\_\_\_\_\_  
\_\_\_\_\_

9. Does your child have any HANDICAPS? Yes \_\_\_\_ No \_\_\_\_

10. Other ILLNESSES or DISEASES? Yes \_\_\_\_ No \_\_\_\_

If Yes, What? \_\_\_\_\_

11. Has this child ever been HOSPITALIZED? Yes \_\_\_\_ No \_\_\_\_

If Yes, For What? \_\_\_\_\_

12. Has this child had any serious ACCIDENTS or ingestions? Yes \_\_\_\_ No \_\_\_\_

If Yes, List Type, When & How Treated? \_\_\_\_\_  
\_\_\_\_\_

13. Does this child chew unusual things such as pencils, chalk, cribs, window ledges, paint chips plaster or hair? Yes \_\_\_\_ No \_\_\_\_

14. Has your child had any of the following? Please Circle  
Premature Birth                      Birth Injury or Defect  
Trouble Breathing at Birth        Convulsions / Seizures  
Head Injury                              Allergies of Any kind

Describe: \_\_\_\_\_  
\_\_\_\_\_

**A. DEVELOPMENTAL HISTORY**

How do you comfort your child? \_\_\_\_\_

What are your child's favorite toys? \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

What language is spoken in your home? \_\_\_\_\_

**B. SLEEPING**

Do you have any special ways of helping your child go to sleep? Yes \_\_\_\_ No \_\_\_\_  
What? \_\_\_\_\_

\* Does your baby cry when going to sleep? Yes \_\_\_\_ No \_\_\_\_

What is your child's present sleeping schedule?

Night Time: From \_\_\_\_\_ To \_\_\_\_\_

AM Nap: From \_\_\_\_\_ To \_\_\_\_\_

PM Nap: From \_\_\_\_\_ To \_\_\_\_\_

Does your baby need a pacifier? Yes \_\_\_\_ No \_\_\_\_

Does your baby need a blanket? Yes \_\_\_\_ No \_\_\_\_

Does your child need a toy? Yes \_\_\_\_ No \_\_\_\_

**C. FEEDING**

\* Is the baby breast-fed? \_\_\_\_ Bottle-fed? \_\_\_\_

\* Type of bottle: \_\_\_\_\_ Type of nipple: \_\_\_\_\_

\* Type of formula: \_\_\_\_\_

\* How many ounces taken between burps? \_\_\_\_\_

What is your child's present eating schedule?

(Specify amount & time for milk, formula, juice & food)

Breakfast \_\_\_\_\_

AM Supplements \_\_\_\_\_

Lunch \_\_\_\_\_

PM Supplements \_\_\_\_\_

Has your child had any feeding problems? Yes \_\_\_\_ No \_\_\_\_

If Yes, What? \_\_\_\_\_

**D. TOILETING**

How frequently does your child have a bowel movement? \_\_\_\_\_

Appearance of B.M. \_\_\_\_\_

Is your child toilet trained? Yes \_\_\_\_ No \_\_\_\_

What word does your child use for urination? \_\_\_\_\_

Does he/she use a potty-chair? Yes \_\_\_\_ No \_\_\_\_

Does your child frequently have diaper rash? Yes \_\_\_\_ No \_\_\_\_

How would you like us to treat your child's diaper rash? \_\_\_\_\_

Is there anything additional that you would like to tell us about your child?

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_