

HEALTH HISTORY – PRESCHOOL / SCHOOL AGE
(To be completed by parent before admission)

Child's Name _____ Age _____ Birth 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 headaches, leg aches, stomachaches or other PAIN? Yes ____ No ____
6. Has this child had trouble with his/her EYES or VISION? Yes ____ No ____
7. Is 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?
Date: _____ (If over 6 months, check "NO") Yes ____ No ____
11. Was all the DENTAL WORK suggested completed? Yes ____ No ____
12. Was this child seen by a Doctor since the last clinic exam? Yes ____ No ____
If Yes, When? _____
What for? _____
13. Is child taking any MEDICATIONS at this time? Yes ____ No ____
If Yes, What medications? _____
Why? _____

14. PAST HISTORY – Circle any of the following this child has ever had:

- | | |
|--|--|
| “Red” or “Hard” Measles | Premature Birth |
| German or 13-Day Measles | Trouble Breathing at Birth |
| Mumps | Birth Injury or Defect |
| Chickenpox | Head Injury |
| Meningitis | Allergies of Any Kind (food/environmental) |
| Scarlet Fever | Convulsions, Seizures, Fits |
| Diabetes | Heart Trouble |
| Pneumonia | Physical Handicap |
| High Fever
(Above 104 for 3 or more days) | |

15. RECENT HISTORY – Circle any the child has had recently:

- | | |
|------------------------------|----------------------------|
| Frequent Urination | Dizziness, Fainting Spells |
| Burning or Painful Urination | Tires Easily |
| Constantly Cold | Swollen Glands |
| Bowel Problems | Difficulty Hearing |
| Shortness Breath | Bleeds Easily |
| Joint Pain | |

16. Other ILLNESSES or DISEASES? Yes ___ No ___
 If Yes, What? _____
17. Has this child ever been HOSPITALIZED? Yes ___ No ___
 If Yes, For What? _____
18. Has this child had any serious ACCIDENTS or ingestions? Yes ___ No ___
 If Yes, List Type, When & How Treated? _____
19. Does this child have any physical RESTRICTIONS? Yes ___ No ___
 If Yes, What? _____
20. Has a MEDICAL SPECIALIST ever seen this child? Yes ___ No ___
 If Yes, Who? _____
 Why? _____
21. Has this child ever had a SICKLE CELL TEST? Yes ___ No ___
 When? _____

A. GROWTH AND DEVELOPMENT

1. Does this child get along well with:
- Mother? Yes ___ No ___
 Father? Yes ___ No ___
 Brothers? Yes ___ No ___
 Sisters? Yes ___ No ___
 Other Children? Yes ___ No ___

COMMENTS: _____

2. Are you concerned about your child in any of the following areas?
- a. Bed-Wetting? Yes ___ No ___
 b. Wetting during the day? Yes ___ No ___
 c. Difficulty going to bed or staying in bed? Yes ___ No ___
 d. Bad dreams, wakefulness or disturbed sleep? Yes ___ No ___
 e. Biting nails or nervous habits? Yes ___ No ___
 f. Thumb sucking? Yes ___ No ___
 g. Stammering or stuttering? Yes ___ No ___
 h. Irritability easily upset or feelings hurt easily? Yes ___ No ___
 i. Restlessness, over activity? Yes ___ No ___
 j. Day dreaming, mind not on what he/she is doing? Yes ___ No ___
 k. Overly cautious, fearful or shy? Yes ___ No ___
 l. Wanting too much attention, comfort or support?
 Clinging? Yes ___ No ___
 m. Breath holding? Yes ___ No ___
 n. Contrary, stubborn, uncooperative, disobedient? Yes ___ No ___
 o. Selfishness, inability to share? Yes ___ No ___
 p. Jealousy? Yes ___ No ___
 q. Anger, temper tantrums? Yes ___ No ___
 r. Destroying things on purpose? Yes ___ No ___
 s. Clumsiness, awkwardness? Yes ___ No ___
 t. Too much concern about sex for age? Yes ___ No ___

COMMENTS: _____

3. What experience has this child had with groups? (Daycare, Preschool, Head Start, Church or Temple school) _____
4. Is there anything additional that you would like to tell us about your child?

Parent/Guardian Signature _____ Date _____