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? __________________________________________________________________

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 ______________