Mildly Ill Program
Center for Child Development

PROVIDENCE Health & Services Alaska

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 _____