PROVIDENCE Health & Services Alaska

Mildly Ill Program
Center for Child Development

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 has 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? Yes ____ No ___
      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_____