

## Health History and Family Factors

**Note to the parents:**

The purpose of this health and family history form is to identify your child's health risk factors, describe specific health or developmental concerns you may have, assess your child's physical and psychosocial growth and development, determine if there are any family circumstances that may affect your child's learning, and establish what health resources you are currently using.

Child's Name (last, first, middle initial)		Sex (M/F)	Birthdate
Address		Zip Code	Home Phone
Father's Name (and address if different)	Phone (day)	<i>Who takes care of your child most of the time?</i> <input type="checkbox"/> day care <input type="checkbox"/> nursery school/preschool <input type="checkbox"/> other early childhood/family program <input type="checkbox"/> any services for children with special needs	
Mother's Name (and address if different)	Phone (day)		
Physician's name	Phone		
Address		Date of last complete physical exam	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, carrier	

**Family Information**

	Name	Relationship to child	Highest grade completed	Age	Male or Female
List Family Members					

	Name	Relationship
List others living in your home	1.	
	2.	
	3.	

**Family Factors**

Answering the questions in this section is optional. You are not required to provide this information. Choosing to answer these questions will not affect your child's school entrance but will aid in your child's educational process.

What are some of your family's strengths? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has there been any unusual stress in your family that might affect your child? (examples – new brother or sister, divorce, death of a family member, moving, financial problems.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Is there anything else you would like to discuss which might be interfering with your child's growth and development?  
 \_\_\_\_\_  
 \_\_\_\_\_

## Past Health History

<b>Pregnancy</b>	<p>Mother had the following problems during this child's pregnancy:</p> <table border="0"> <tr> <td><input type="checkbox"/> Rash/German measles</td> <td><input type="checkbox"/> Toxemia/high blood pressure</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Flu/infection</td> <td><input type="checkbox"/> Urinary tract infection</td> </tr> <tr> <td><input type="checkbox"/> Vaginal bleeding or infection</td> <td><input type="checkbox"/> Blood transfusions</td> <td><input type="checkbox"/> RH incompatibility</td> </tr> <tr> <td><input type="checkbox"/> Heart condition</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Depression</td> </tr> </table> <p><input type="checkbox"/> Other, describe: _____</p> <p><input type="checkbox"/> Mother received x-rays or other treatments during pregnancy. If yes, describe: _____</p> <p><input type="checkbox"/> Mother was hospitalized or had surgery. If yes, describe: _____</p>	<input type="checkbox"/> Rash/German measles	<input type="checkbox"/> Toxemia/high blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Flu/infection	<input type="checkbox"/> Urinary tract infection	<input type="checkbox"/> Vaginal bleeding or infection	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> RH incompatibility	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression															
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<b>Birth</b>	<p>Check all boxes that apply to your child.</p> <p>When my child was born:</p> <p><input type="checkbox"/> There were difficulties during labor and/or delivery.</p> <p><input type="checkbox"/> My child had difficulties at birth or shortly after birth.</p> <p><input type="checkbox"/> Actual birth weight _____ lbs., _____ oz.</p> <p><input type="checkbox"/> My child did not go home from the hospital with his/her mother.</p>																											
<b>Childhood Illness</b>	<p>My child has had the following diseases:</p> <table border="0"> <tr> <td><input type="checkbox"/> Meningitis</td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/> German or three-day measles (Rubella)</td> </tr> <tr> <td><input type="checkbox"/> Rheumatic fever</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> "Red" or "hard" measles</td> </tr> <tr> <td><input type="checkbox"/> Pneumonia</td> <td><input type="checkbox"/> Scarlet fever</td> <td><input type="checkbox"/> High fever (104 for longer than two days)</td> </tr> <tr> <td><input type="checkbox"/> Strep infections</td> <td><input type="checkbox"/> Chicken pox</td> <td></td> </tr> </table> <p><input type="checkbox"/> Has had other serious illnesses for which he/she was not hospitalized. If so, describe: _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> Has been hospitalized. If so, list dates, reason, and treatment given: _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> Has had one or more serious injuries (broken bones, stitches, strains, sprains). If so, please list: _____</p> <p><input type="checkbox"/> _____</p>	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> German or three-day measles (Rubella)	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> "Red" or "hard" measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> High fever (104 for longer than two days)	<input type="checkbox"/> Strep infections	<input type="checkbox"/> Chicken pox																
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<b>Special Health Needs</b>	<p><input type="checkbox"/> Has had special tests for health problems.</p> <p><input type="checkbox"/> Has been seen by medical specialists.</p> <p><input type="checkbox"/> Has had some chronic health problems. Please describe: _____</p> <p><input type="checkbox"/> Takes medication for a health problem.</p>																											
<b>Growth and Development</b>	<p>Were there any delays with your child's development? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____</p> <p>_____</p>																											

## Current Health Status (check all that apply to your child)

<b>Skin</b>	<p><input type="checkbox"/> Has problems with rashes.</p> <p><input type="checkbox"/> Bruises easily.</p> <p><input type="checkbox"/> Has unexplained lumps or spots.</p>
<b>Head</b>	<p><input type="checkbox"/> Has had one or more head injuries.</p> <p><input type="checkbox"/> Has headaches.</p> <p><input type="checkbox"/> Has had a period of unconsciousness as a result of injury.</p>
<b>Eyes</b>	<p><input type="checkbox"/> Has problems with his/her eyes such as squinting, crusty eyelids, mattering.</p> <p><input type="checkbox"/> Eyes cross or wander separately.</p> <p><input type="checkbox"/> Wears glasses or contact lenses.</p> <p>Do you have concerns about your child's vision? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____</p>

<b>Ear, Nose, and Throat</b>	<input type="checkbox"/> Has had two or more throat infections in a year. <input type="checkbox"/> Has frequent nosebleeds. <input type="checkbox"/> Has swollen glands frequently. <input type="checkbox"/> Seems to have trouble hearing. <input type="checkbox"/> Has had ear problems two or more times within a year. <input type="checkbox"/> Has had earaches or discharge from the ear within the past six months. <input type="checkbox"/> Has had ventilation (PE) tubes put in his/her ears or other treatment.
<b>Respiratory</b>	<input type="checkbox"/> Has had six to ten colds in a year. <input type="checkbox"/> Has a severe cough with colds. <input type="checkbox"/> Has been exposed to tuberculosis. <input type="checkbox"/> Has shortness of breath, asthma, or wheezing at times. <input type="checkbox"/> Has trouble getting rid of coughs or colds.
<b>Cardio-Vascular</b>	<input type="checkbox"/> Hands and fingers turn blue. <input type="checkbox"/> I have been told that my child has a heart murmur. <input type="checkbox"/> Has heart trouble. <input type="checkbox"/> Seems to tire easily.
<b>Gastro-Intestinal</b>	<input type="checkbox"/> Vomits frequently. <input type="checkbox"/> Has frequent stomachaches. <input type="checkbox"/> Has diarrhea frequently. <input type="checkbox"/> Has bloody stools. <input type="checkbox"/> Has trouble with constipation. <input type="checkbox"/> Seems to have a problem with foods disagreeing with him/her.
<b>Urinary</b>	<input type="checkbox"/> Is not toilet trained. <input type="checkbox"/> Has trouble wetting during the day. <input type="checkbox"/> Has trouble with bedwetting. <input type="checkbox"/> Has had a kidney or bladder infection.
<b>Skeletal</b>	<input type="checkbox"/> Complains of pains in his/her arm, legs, back, or joints. <input type="checkbox"/> Limp, toes in or toes out. <input type="checkbox"/> Has had a broken bone, cast, brace, or corrective shoes.
<b>Neuro-Muscular</b>	<input type="checkbox"/> Loses his/her balance in unusual ways. <input type="checkbox"/> Has staring spells. <input type="checkbox"/> Has some unexplained movements or jerks. <input type="checkbox"/> Seem to fall down more than other children. <input type="checkbox"/> Has had convulsions or seizures. <input type="checkbox"/> Is clumsy and awkward. <input type="checkbox"/> Has a weakness in his/her body.
<b>Education</b>	<input type="checkbox"/> Has your child ever been referred for special testing? By whom _____ Type of testing _____ <input type="checkbox"/> Has your child received additional help outside the classroom? Name of provider _____ <input type="checkbox"/> Does your child have an IEP (Individual Education Program) or an AIS (Alternative Intervention Strategies)? If yes, explain: _____

List any medications your child takes regularly: \_\_\_\_\_

Describe any physical limitations or restrictions your child has: \_\_\_\_\_

Describe any concerns you have about your child: \_\_\_\_\_

Are there other children in your family who may have developmental problems? \_\_\_\_\_

Do you have any concerns about your child's behavior? Please explain: \_\_\_\_\_