Health History Check List

Child's Name______________________ D.O.B._________ Parent's Name_____________________________

The information below will help SHADES of Development provide the best possible care for your child's special needs. Please include any pertinent information, not discussed in the questions below, that may assist us with your child's care. Circle the correct answer.

Pregnancy and Birth

❑Yes ❑No 1) Were there any problems with the pregnancy or birth of your child?__________________

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❑Yes ❑No 2) Was his/her birth weight under 5 1/2 pounds?

❑Yes ❑No 3) Did your baby have any problems in the hospital? If yes explain____________________

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Medical Information

❑Yes ❑No 4) Has your child ever been hospitalized overnight? If yes, why?______________________

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❑Yes ❑No 5) Does your child have asthma or wheezing?

❑Yes ❑No 6) Does your child have speech or hearing problems?

❑Yes ❑No 7) Has your child had more than two ear infections in one year?

❑Yes ❑No 8) Has your child had tonsillitis?

❑Yes ❑No 9) Does your child have trouble with his/her eyes or with seeing?

❑Yes ❑No 10) Does your child have seizures, fits, or shaking spells?

❑Yes ❑No 11) Has your child had a bladder or kidney infection?

❑Yes ❑No 12) Does he/she have burning when urinating?

❑Yes ❑No 13) Have you ever been told that your child has a heart murmur?

❑Yes ❑No 14) Is your child able to play as hard as other children?

❑Yes ❑No 15) Has your child ever had a bumpy or swollen reaction to a TB test?

❑Yes ❑No 16) Has your child ever been exposed to TB?

❑Yes ❑No 17) Has your child ever had worms?

❑Yes ❑No 18) Does your child have any type of problem with his/her genital area?__________________

❑Yes ❑No 19) Does your child have any bladder control problems?

❑Yes ❑No 20) Has your child ever been tested for ADD or ADHD?

❑Yes ❑No 21) Has your child ever been diagnosed with ADD or ADHD?

❑Yes ❑No 22) Is your child currently taking any type of medication? If so, what?___________________

❑Yes ❑No 23) Is your child a hemophiliac, free bleeder?

❑Yes ❑No 24) Does your child have any allergies or reactions to medicine, insects, food, sunscreen etc? If so, what?____

❑Yes ❑No 25) Is your child on a heart monitor?

❑Yes ❑No 26) Does your child have tubes in his/her ears?

Older Girls

❑Yes ❑No 27) Has your daughter began her menstrual cycle? If yes, how old was she when she began?

❑Yes ❑No 28) Does she have any problems with her menstrual cycle?

General Development

❑Yes ❑No 29) Is your child in special education classes at school?

❑Yes ❑No 30) Does your child get along with other children?

❑Yes ❑No 31) Is your child usually happy?

❑Yes ❑No 32) Does your child have any special problems not listed above? If so, list on the back.

33) When was your child's last doctor visit? Month_________________ Year_____________