Health History for Infants and Toddlers
(To be completed by parent before admission)

Child's Name: ______________________________ **Birthdate:** ____________ **Date:** _________

HEALTH HISTORY

1. Does your child seem well most of time? ☐ Yes ☐ No
2. Is your child currently taking any medications? ☐ Yes ☐ No
   If yes, please list what and why____
3. In the past year, has your child had 3 or more ear infections? ☐ Yes ☐ No
4. Has your child been seen by medical specialist other than their regular MD? ☐ Yes ☐ No
   If yes,who?____why?_____________________________
5. What arrangements have you made for the care of your child should he/she become ill at the center?
   ____
6. Does your child have any disabilities? ☐ Yes ☐ No
   If yes, please describe:____
7. Has your child ever had surgery? ☐ Yes ☐ No
   If yes, for what:____
8. Has your child been hospitalized? ☐ Yes ☐ No
   If yes, for what: ____
9. Has your child had any serious accidents or poisonings? ☐ Yes ☐ No
   If yes, explain: ____
10. Has your child had any of the following (please circle):
    Premature Birth   Birth Injury or Defect   Trouble Breathing at Birth
    Convulsions/Seizures   Head Injury   Other- describe: ________________________

FEEDING HISTORY

1. Is your baby breast-fed, bottle-fed or a combination? ____
2. If you use formula, what brand? (infants only)____
3. How many ounces taken between burps? (infants only)____________________________________
4. Does your child feed himself/herself? ☐ Yes ☐ No
5. Does your child use a sippy cup? If not, at what age might you introduce one? _________________
6. In your family, what is the typical age when a child feeds himself/herself? _______________________
7. Has your child had any feeding problems? ☐ Yes ☐ No
   Describe: ____

TOILETING HISTORY

1. How frequently does your child have a bowel movement? ____________________________________
2. Is your child toilet trained? ☐ Yes ☐ No
3. Does he/she use a potty-chair? ☐ Yes ☐ No
4. Does your child frequently have diaper rash? ☐ Yes ☐ No
5. How would you like us to treat your child's diaper rash? _____________________________________

Is there anything else about your child's health history you would like to share? ______________

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PARENT SIGNATURE____**DATE**____________________