



Family Child Development Center Health History for Preschool

(To be completed by parent before admission)

Child's Name: _____

Birthdate: _____ Date: _____

HEALTH HISTORY

1. Does your child seem well most of the time? Yes No
2. In the last year, has your child had 3 or more ear infections? Yes No
3. In the last year, has your child had more than 3 colds or sore throat infections with a fever? Yes No
4. Does your child have trouble getting rid of severe coughs? Yes No
5. Does your child complain frequently of headache, leg ache, stomachache, or other pain? Yes No
6. Has your child had trouble with his/her eyes or vision? Yes No
7. Is your 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 (PICA)? Yes No
9. Does this child have any trouble sleeping? Yes No
10. When was your child 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 your child seen by a doctor since last annual clinic exam? Yes No
If yes, when: _____ What for: _____
13. Is your child taking any medications (Tylenol, laxatives) Yes No
If yes, what medication: _____ What for: _____
14. Past History—Circle any of the following your child has ever had:
Red measles Kidney or bladder infection Birth injury or defect
German measles Diabetes Head injury
Mumps Pneumonia Allergies (eczema, hives, hay fever, food or drug)
Chickenpox Physical handicap Wheezing or asthma
Meningitis Premature birth Convulsions, seizures, fits
Scarlet fever Trouble breathing at birth Heart trouble
High fever (above 104 for 3 or more days)
15. Recent History—Circle any the child has had recently:
Frequent urination Bowel problems Shortness of breath
Small stream or dribbling Dizziness, fainting spells Difficulty hearing
Burning or painful urination Tires easily Bleeds easily
Constant cold Swollen glands Joint pain
16. Has your child had other illnesses or diseases? Yes No
If yes, explain: _____
17. Has your child been hospitalized? Yes No
If yes, explain: _____
18. Has your child had any serious accidents or ingestions? Yes No
If yes, list type, when, how treated: _____

19. Does your child have any physical restrictions? Yes No
 If yes, explain: _____
20. Has your child ever been seen by a medical specialist other than a regular MD? Yes No
 If yes, who: _____ Reason: _____
21. Has your child ever has a sickle cell test (if yes, when _____) Yes No

GROWTH AND DEVELOPMENT HISTORY

1. Does your child get along well with:
- | | |
|---|---|
| Mother <input type="checkbox"/> Yes <input type="checkbox"/> No | Brothers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Father <input type="checkbox"/> Yes <input type="checkbox"/> No | Sisters <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other children <input type="checkbox"/> Yes <input type="checkbox"/> No | Other adults <input type="checkbox"/> Yes <input type="checkbox"/> No |

Comments: _____

2. Are you concerned about your child in any of the following areas:
- | | | |
|---|------------------------------|-----------------------------|
| a. Bedwetting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Wetting during the day | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Difficulty going to bed or staying in bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Bad dreams, wakefulness, disturbed sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Biting nails, nervous habits | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Thumbsucking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Stammering or stuttering | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Restlessness, overactivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Day dreaming, mind not on what he is doing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Irritability, easily upset, feelings hurt easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Overly cautious, fearful, shy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Wanting too much attention, comfort, clinging | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Breath holding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Contrary, stubborn, uncooperative, disobedient | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o. Selfishness, inability to share | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p. Jealousy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q. Anger, temper tantrums | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r. Destroying things on purpose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| s. Clumsiness, awkwardness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| t. Too much concern about sex for age | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: _____

3. What experience has your child had with groups? (child care, preschool, Head Start, church or temple) _____

3. Is there anything additional that you would like to tell us about your child? _____

PARENT SIGNATURE _____ **DATE** _____