HEALTH HISTORY

Child's Name: _____ DOB: __/__/__

HOSPITALIZATIONS/ILLNESS	YES	NO	EXPLAIN ALL **YES** ANSWERS
Did mother have abnormal Pregnancy? Birth Weight ___lbs. ___ozs.			
Has child ever been hospitalized?			
Has child ever had surgery?			
Has child ever had a serious illness?			
Has child had frequent stomach problems?			
Does child have urinary infections or trouble Urinating?			
Does child have difficulty seeing?			
Does child wear glasses?			
Does child have any problems with ears/hearing?			
Does child wear a hearing aid?			
Does child have tubes in ears?			
Has child ever had a seizure?			
Is child taking any type of medication now?			
Does your child have a dentist?			
Does your child have a physician?			
Has your child ever had Chicken Pox?			
Does your child have any of the following: Asthma, Diabetes, Liver Disease, Bleeding, Tendencies, Heart/Blood Vessel Disease, Sickle Cell Disease. Please list on right side of form if you answered yes to anyone above.			
Does your child have any food allergies? (Such as: Peanuts, fruits, vegetables etc…)			
Does your child have any allergies that require taking a prescription medication? Will need a plan if a child has an allergy.			
List any other conditions that we haven't talked About that get in the way of child's activities.			
Does your child have any difficulty saying what He/she wants?			
Does your child Nap? If yes - How long_____			
Does your child need help with bathroom?			
Is your child often cranky and you doing know why?			
Has there been any recent changes or problems in your child's life that may affect his/her Behavior?			

Signature of Person Interviewed:_____Date:__/__/__ Relationship:_____

Staff Interviewer: _____ Date:__/__/__ Updated ____/____/___ Updated ____/____/___