HEALTH HISTORY

CHILD'S NAME: **DATE:**

SECTION 1: HEALTH

Does or has your child…

1.) seem well most of the time?	YES	NO
2.) had 3 or more episodes of ear trouble within one year?	YES	NO
3.) have more than 3 colds, or sore throats within one year, with a fever?	YES	NO
4.) have problems getting rid of severe colds?	YES	NO
5.) complain for frequent headache, leg ache, stomach aches, or other pains?	YES	NO
6.) had trouble with eyes, or vision?	YES	NO
7.) have a good appetite	YES	NO
8.) have difficulty sleeping?	YES	NO

When was your child last seen by…

9.) a dentist? Date: Dental work performed:

10.) a physician? Date: For what reason?

11.) Is your child taking any medications now, precribed, or otherwise? YES NO

List ALL medications:

Explain reason for medications:

12.) **PAST HISTORY**

Check ALL that apply

- Red/Hard Measles
- German/13 Day Measles
- Mumps
- Chicken Pox
- Meningitis
- Scarlet Fever
- Kidney/Bladder Infection
- Juvenile Diabetes
- Pneumonia
- Premature birth
- Trouble breathing at birth
- Birth injury or defect
- Head Injury
- Allergies
- Convulsions/Siezures/Fits
- Heart Trouble
- High Fever (above 104 degrees for 3 days or more

13.) **CURRENT HISTORY**

Check ALL that apply

- Frequent urination
- Small stream, or dribbling
- Burining or painful urination
- Constant Cold
- Bowel problems
- Bleeds easily
- Dizzieness/Fainting spells
- Tires easily
- Swollen glands
- Difficulty hearing
- Joint pain

14.) Other illnesses, or diseases?	YES	NO
15.) Has your child ever been hospitalized?	YES	NO
16.) Has your child had any serious accident, or ingestion?	YES	NO
17.) Does your child have any physical restrictions?	YES	NO
18.) Has your child been tested, or treated for any chronic, or life threatening disease?	YES	NO

IF YOUR ANSWER TO ANY QUESTION NUMBERED 14 THROUGH 18, WAS YES,
PLEASE NOTE THE QUESTION NUMBER AND GIVE AN EXPLANATION RELATIVE TO THE QUESTION

SECTION 2: GROWTH AND DEVELOPMENT

19.) Are you concerned about your child in any of the following "Growth and Development areas?

a.) Bedwetting?
b.) wetting during the day?
c.) Difficulty going and staying in bed?
d.) Bad dreams, wakefulness, disturbed sleep?
e.) Biting nails, nervous habits?
f.) Thumbsucking?
g.) Stammering, or stuttering?
h.) Irritability, easily upset, feelings hurt easily?
i.) Restlessness, over activity?
j.) Day dreaming, mind not on what he/she should be doing?
k.) Overly cautious, fearful, shy?
l.) Wanting too much attention, comfort, support, or clinging?
m.) Breath holding?
n.) Contrary, stubborn, unccoperative, disobedient?
o.) Selfishness, inability to share?
p.) Jealousy?
q.) Anger, temper tantrums?
r.) Destroying thiings on purpose?
s.) Clumsiness, awkwardness?

You can elaborate on any "Growth and Development questions on the back of this form as provided.

20.) If there is anything additional that you would like for us to know about your child, please continue on the back of this form, in the space provided.

HEALTH HISTORY
COMMENTS SECTION

CHILD'S NAME: **DATE:**

ADDITIONAL COMMENTS ON QUESTIONS 14 THROUGH 18

IF NONE CHECK HERE

GROWTH AND DEVELOPMENT COMMENTS

IF NONE CHECK HERE

ADDITIONAL COMMENTS WITH REGARD TO YOUR CHILD, THAT YOU WOULD LIKE US TO KNOW

IF NONE CHECK HERE