EARLY CHILDHOOD HEALTH HISTORY QUESTIONNAIRE

Student's Name _____ Date of Birth _____

Parents/Guardian _____ Daytime Phone Number_____

Child's Doctor _____ Cell/Emergency Number_____

Prenatal

Were you sick during your pregnancy? Yes_____ No _____

If yes, please explain _____

Full term _____ Premature _____ Complications_____

What type of delivery did you have? Normal _____ C-Section _____

Neonatal

How much did your baby weigh at birth? _____

Was your baby sick in the first few days of life? Yes _____ No _____

If yes, please explain _____

Developmental Milestones (age at which the child)

Sat up _____ Crawled _____ Walked _____ Talked _____ Toilet Trained _____

Health Problems

Has your child ever had any of the following?

	Yes	No	Age		Yes	No	Age
Heart disease	___	___	___	Seizure/Convulsion	___	___	___
Fainting	___	___	___	Diabetes	___	___	___
Kidney Disease	___	___	___	Ear Infections	___	___	___
Sickle Cell	___	___	___	Lead Poisoning	___	___	___
Hearing Problem	___	___	___	Learning Problem	___	___	___
Vision Problem	___	___	___	Broken Bones	___	___	___
Surgery	___	___	___	Asthma	___	___	___

Explain any "yes" answers and list any other health problems.

_____

_____

_____

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Activity restrictions specified by MD (note required) _____

Hospitalizations

Has your child ever been hospitalized for any reason? Yes _____ No _____
Reason for hospitalization _____ How many days? _____ Year _____
Reason for hospitalization _____ How many days? _____ Year _____

Asthma

Has your child ever had asthma? Yes _____ No _____
How often does your child have asthma attacks? _____
What triggers your child's asthma? _____
Has your child used asthma medicine in the past 2 years? Yes _____ No _____
If yes, please indicate medicine used _____

Allergies

To food? Yes _____ No _____ To medicine? Yes _____ No_____

If yes, please list things child is allergic to and indicate symptoms:

_____

_____

Anaphylaxis? Yes _____ No _____ Epipen? Yes _____ No _____

Medications

Does your child take any prescription medicine at home? Yes _____ No _____
If yes, please list medicine(s) _____

_____

Will your child be taking prescription medicine at school? Yes _____ No _____
If yes, what medicine(s)? _____

Parents/Guardian Signature: _____Date_____

I GIVE PERMISSION TO SHARE THIS INFORMATION WITH STAFF MEMBERS INVOLVED IN MY CHILD'S CARE AND EDUCATION.

Parents/Guardian Signature: _____Date_____

Reviewed by:_____Date_____