

**MEDICAL HISTORY** of \_\_\_\_\_ Birth date: \_\_\_\_\_

Please complete this so that we may know how to best serve you, your family, and your child.

- I. Family History:**
- |                        |     |    |                                |     |    |
|------------------------|-----|----|--------------------------------|-----|----|
| Is this child adopted? | Yes | No | in "foster care" now?          | Yes | No |
|                        |     |    | In foster care in the past?    | Yes | No |
| In "kinship care now?" | Yes | No | In "kinship" care in the past? | Yes | No |

Who lives in your house? Please provide name, age, education completed, and job or skills of each person

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**II. This Child's Medical history:**

**A. Mother's history during pregnancy:** Blood type \_\_\_\_\_.

Mother's Age at delivery \_\_\_\_\_ yrs. Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_.

Problems during pregnancy : None / Yes: \_\_\_\_\_.

**B. Birth:** Type of delivery: Vaginal / C-section On time / Premature Weeks gestation \_\_\_\_\_.

Length \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs \_\_\_\_\_ oz

Problems after birth: None / Yes: \_\_\_\_\_.

**C. Date of last check up:** \_\_\_\_\_ Name of Dr / Practice \_\_\_\_\_.

Phone # / Address \_\_\_\_\_.

**D. Please list all operations, hospitalizations, physical and mental health problems, accidents, injuries, ER visits:**

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**E. If your child or family member has ever had any of the following, please circle it:**

.....None

- |                |                |                           |               |                   |
|----------------|----------------|---------------------------|---------------|-------------------|
| AIDS or HIV    | Anemia         | Arthritis                 | Asthma        | Bladder infection |
| Cancer         | Chickenpox     | Diabetes                  | Diphtheria    | Eczema            |
| Epilepsy       | Heart disease  | Hepatitis (liver disease) | Hernia        | Kidney disease    |
| Lead Poisoning | Leukemia       | Lung infections           | Measles       | Mononucleosis     |
| Mumps          | Pneumonia      | Rheumatic Fever           | Scarlet Fever | Thyroid disease   |
| Tuberculosis   | Whooping cough | Other: _____              |               |                   |

**F. Diet:** Does your child eat / drink: (Circle appropriate items please)

Breast milk / 1%, 2%, chocolate, strawberry, whole milk / formula? How many times / day? \_\_\_\_\_.

Juice ( which kind? \_\_\_\_\_ ) How many times / day? \_\_\_\_\_.

Water - tap / bottled, no fluoride / bottled with fluoride (circle those used) How many times / day? \_\_\_\_\_.

Soda (which kinds? \_\_\_\_\_) How many times / day? \_\_\_\_\_.

Meats / eggs / beans / poultry / fish / peanut butter (circle those eaten) How many times / day? \_\_\_\_\_.

Vegetables - which ones? \_\_\_\_\_ How many times / day? \_\_\_\_\_.

Fruits - which ones? \_\_\_\_\_ How many times / day? \_\_\_\_\_.

Breads / cereals - which ones? \_\_\_\_\_ How many times / day? \_\_\_\_\_.

How many times a week do you eat "fast food" or "eat out"? \_\_\_\_\_.

Does your family or child have any special diets or food preferences? ..... Yes No  
If yes, please describe

**G. Development / Education:** What school does your child attend? \_\_\_\_\_ Grade \_\_\_\_\_  
Achievement: A's B's C's D's F's Outstanding / Satisfactory / Unsatisfactory Honor Roll / Merit Roll / trouble  
Do you have concerns that your child's development is not normal? ..... Yes No  
speech development / coordination / writing / drawing / social skills / bullying  
School performance: math / science / social studies / writing / behavioral

**H. Has your child ever participated in:** (Circle all that apply)  
Clubs / After school sports / Bilingual programs / Emotional support classes / Day care  
Learning support classes / Gifted/Talented programs / Speech therapy / Headstart / Evenstart / Life skills class'  
Special education program / Organized activity (scouts, leagues, etc)

**I. Habits:**  
Does your child ever wet the bed or their pants - nighttime or daytime? ..... Yes No  
Does your child soil their pants - daytime or nighttime? ..... Yes No  
Do you read with your child every day for at least 30 minutes? ..... Yes No  
What is your bedtime routine with your child?

**J. Health / fitness:**  
How many TVs \_\_\_VCRs \_\_\_ DVD players\_\_\_ Computers\_\_\_ are there in your home? In child's bedroom? Yes No  
How much time" does your child have daily (TV, VCR, DVD, computer games, internet access)? \_\_\_\_\_ hrs  
Does your child leave on light, music, or TV when they sleep? ..... Yes No  
Do they cough, snore, or have breathing difficulty at night? ..... Yes No  
Do you know anyone who smokes cigarettes? ..... Yes No  
uses marijuana, cocaine, heroin, or other illegal substances? ..... Yes No  
What does your child do for exercise? \_\_\_\_\_  
What weekend activities does your child participate in? \_\_\_\_\_  
What activities do you enjoy as a family? \_\_\_\_\_

**K. Safety:**  
Does your child "Stop, Look, and Listen" before crossing the street?..... Yes No  
Wear a seat belt always when in a vehicle? ..... Yes No  
Sit in a car seat or booster seat? Rear facing / front facing (circle one) ..... Yes No  
Wear a helmet ( and knee and elbow pads) when riding a bike?..... Yes No  
when skateboarding?.....Yes No  
Are weapons (guns and knives ) in your home and your child's daycare home secured away from children? Yes No  
Is ammunition stored separate? .....Yes No  
Is there peeling, flaking, or chewed paint in your home, stairway, or play areas?..... Yes No  
Does your family have and practice a fire evacuation plan in case of emergency? ..... Yes No  
Have you ever been hurt physically or emotionally by someone?..... Yes No  
Are you concerned that someone might hurt you physically or emotionally?..... Yes No  
Are medicines stored locked and away from children?..... Yes No

**L. Other:**  
Have you considered organ donation? Would you like more information?..... Yes No  
Do you have a living will (about what you want done with your body if you should die)? ..... Yes No  
Would you like more information? ..... Yes No  
Do you have questions for us that you want to write here so that they won't be forgotten?..... Yes No