HEALTH INFORMATION FORM

Date: _____

Name: _____ Birthdate: _____

ACUTE OR CHRONIC ILLNESS

___ Yes ___ No Asthma
___ Yes ___ No Cerebral Palsy
___ Yes ___ No Cystic Fibrosis
___ Yes ___ No Diabetic (insulin dependent)
___ Yes ___ No Epilepsy
___ Yes ___ No Frequent colds
___ Yes ___ No Frequent sore throat
___ Yes ___ No Hyperthyroidism
___ Yes ___ No Hypothyroidism
___ Yes ___ No Allergies other than those related to food/drugs
If yes, describe _____
___ Yes ___ No Headaches
___ Yes ___ No Stomachaches
___ Yes ___ No Bed-wetting
___ Yes ___ No Mental illness (ex. autism, mental retardation, etc.)
If yes, describe _____
___ Yes ___ No Cancer
If yes, describe _____
___ Yes ___ No Heart disease
If yes, describe _____

Please answer the following questions about the pregnancy, labor, and delivery of your child.

Did the mother have difficulties during the pregnancy, labor, or delivery of your child? _____ If yes, what? _____

Did the mother visit a physician or medical clinic during her pregnancy? _____

Was your child born at home or at any place other than a hospital or medical clinic? _____ If yes, where? _____

Did your child have difficulties at birth or shortly after (for example, jaundice [yellow skin], breathing problems, infection, high fever, feeding problems? _____ If yes, what _____
_____

Did you child weigh less than 5 1/2 pounds at birth? _____ If yes, how much did the child weigh?
_____

Was your child born prematurely? _____ If yes, by how many weeks? _____

Was your child born post-maturely? _____ If yes, by how many weeks? _____

Was your child placed in a neonatal intensive care nursery or high-risk nursery after birth _____ If yes, for how many days? _____

ACCIDENTS

Has your child had any of the following? If yes, describe
___ Yes ___ No Burns requiring treatment _____
_____
___ Yes ___ No Bumps to head requiring treatment _____
_____
___ Yes ___ No Fractures _____
___ Yes ___ No Lacerations or cuts requiring stitches or tetanus booster _____
_____
___ Yes ___ No Near drowning _____

___ Yes ___ No Poisoning _____
___ Yes ___ No Serious falls _____

MEDICATIONS

Is your child using any medicines? If yes, describe

___ Yes ___ No Prescription drugs: Identify drug and condition requiring drug _____
_____
___ Yes ___ No Over-the-counter drugs (nonprescription): Identify drug and reason for use
_____
_____
___ Yes ___ No Drug allergies: Identify drug and reaction _____
_____

NUTRITION

___ Yes ___ No Abdominal pain
___ Yes ___ No Underweight or overweight for age
___ Yes ___ No Allergies related to foods: Identify food and reaction _____
_____
___ Yes ___ No Problems with elimination (bowel movement and/or urination) _____
_____

OPERATIONS

___ Yes ___ No Appendectomy
___ Yes ___ No Hernia
___ Yes ___ No Tonsillectomy
Other _____

HANDICAPPING CONDITION

___ Yes ___ No Scoliosis
___ Yes ___ No Spina bifida
Other _____

ORTHOPEDIC DEVICES

___ Yes ___ No Wheelchair
___ Yes ___ No Special shoes
___ Yes ___ No Crutches
___ Yes ___ No Braces
___ Yes ___ No Helmet

HEARING

___ Yes ___ No Frequent ear aches
___ Yes ___ No Running ear
___ Yes ___ No Hard of hearing
___ Yes ___ No Uses hearing aid

COMMUNICATION

___ Yes ___ No Speech understandable
___ Yes ___ No Stutters/stammers
___ Yes ___ No Lisps

DENTAL

___ Yes ___ No Cavities
___ Yes ___ No Cleft lip or palate
___ Yes ___ No Gum disease
___ Yes ___ No Lost some or all baby teeth
___ Yes ___ No Permanent teeth appearing
___ Yes ___ No Wears dental braces

MENTAL AND EMOTIONAL

___ Yes ___ No Bullies others
___ Yes ___ No Cries often
___ Yes ___ No Toilet trained

BLOOD DISORDERS

___ Yes ___ No Anemia
___ Yes ___ No Leukemia
___ Yes ___ No Hemophilia
___ Yes ___ No Sickle Cell Anemia

HABITS

___ Yes ___ No Sleeps/rests well
___ Yes ___ No Exercises daily
___ Yes ___ No Eats well
___ Yes ___ No Bathes regularly
___ Yes ___ No Brushes teeth regularly

VISION

___ Yes ___ No Wears glasses
___ Yes ___ No Rubs eyes frequently
___ Yes ___ No Squints
___ Yes ___ No Color blind

SKIN AND HAIR

___ Yes ___ No Visible scars
___ Yes ___ No Hives
___ Yes ___ No Scabies
___ Yes ___ No Body lice
___ Yes ___ No Head lice

___ Yes ___ No Lethargic (slow/lazy)
___ Yes ___ No Short attention span
___ Yes ___ No Generally happy

____ Yes ____ No Very sensitive ____ Yes ____ No Very shy

Were there any prenatal or birth complications which affected the child?

_____

Please indicated any other health condition(s) your child has that is not covered on this form

_____

Parent/Guardian's Signature: _____