

# 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 your 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

**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

**HEARING**

Yes  No Frequent ear aches

Yes  No Running ear

Yes  No Hard of hearing

Yes  No Uses hearing aid

**VISION**

Yes  No Wears glasses

Yes  No Rubs eyes frequently

Yes  No Squints

Yes  No Color blind

**COMMUNICATION**

Yes  No Speech understandable

Yes  No Stutters/stammers

Yes  No Lisps

**SKIN AND HAIR**

Yes  No Visible scars

Yes  No Hives

Yes  No Scabies

Yes  No Body lice

Yes  No Head lice

**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

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?

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

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Parent/Guardian's Signature: \_\_\_\_\_