Initial Health History

Student/child name:	DOB:

IDENTIFYING INFORMATION			
Age:	Sex:	Grade:	School:
ADDRESS:			
This form is completed by:		Relationship to Child:	
Reason for assessment:			
Mother's Phone: Home:	Work:	Cell:	e-mail:
Father's Phone: Home:	Work:	Cell:	e-mail:
Child lives with: Both Parents ☐	Mother ☐	Father ☐	Other (explain)
My child has the following health care coverage: Medicaid ☐	CHP+ ☐	Private☐	None ☐
Child's Primary Health Care Provider:		Phone:	
Date of last physical:	Date of Last Visit:	Reason for visit:	
Child' Dentist:	Date of Last Dental exam:		

PREGNANCY AND BIRTH		
Month into pregnancy that medical care began:	Length of pregnancy:	
Were there any medications taken while pregnant?	Explain:	
Were there any complications with pregnancy? No ☐ Yes ☐ Explain:		
Were there any complications with labor and delivery? No ☐ Yes ☐ Explain:		
Length of labor:	Birth Weight:	APGAR scores:
Explain any health issues at birth:		
Did baby require extra stay in hospital? No ☐ Yes ☐ Explain:		

DEVELOPMENTAL HISTORY	Yes	No	Comments
Did your child crawl by 9 months?			
Did your child walk by 18 months?			
Did your child say words by 15 months?			
Was your child toilet trained by 3½ years?			
Were there problems with balance coordination?			
Were there problems with fine motor skills? (buttons, handwriting, picking something up)			
Do you have other concerns about your child's development? (If yes, explain)			

ILLNESSES, HOSPITALIZATIONS, SURGERIES, AND/OR ACCIDENTS
Major Illnesses:
Hospitalization/Surgeries:
Accidents/Injuries:

Body System History (Explain if "yes")	Yes	No	Comments
Teeth: Any Dental concerns?			
Ears: Any known hearing problems?			
Do you have concerns about your child's hearing?			
History of chronic ear infections? (PE tubes? Last infection?)			
Eyes: Does your child have problems seeing?			
Does your child wear glasses? Contacts? Date of last exam?			
Name of Eye Specialist if has one:			
Cardiac: Does your child have any heart problems?			
Does your child fatigue easily or have poor endurance?			

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Respiratory: Does your child have any breathing problems?			
Is he/she prone to upper respiratory infections?			
Does your child have asthma?			
Gastrointestinal and Urinary: Does child have any problems going to the bathroom?			
Bedwetting problems?			
Constipation problems?			
Difficult to train?			
Does your child have dietary/food needs or concerns?			
Do you have concerns about your child's weight?			
Does your child have frequent stomach aches?			
Skeletal and Muscular: Any broken bones? If yes, when, which bone(s)			
Does your child have any physical disabilities?			
Are there any restrictions for activity?			
Neurological: Has your child ever had a seizure?			
Does your child have frequent headaches?			
Has your child ever had a head injury or concussion?			
After injury: Dizziness? ☐ Memory problems? ☐ Headaches? ☐ Fatigue? ☐			
Did your child see a physician? Yes ☐ No ☐ Hospitalized? Yes ☐ No ☐			
Does your child have sleeping/bedtime concerns?			
Goes to bed school nights at _____ Gets up at _____			
TV in bedroom? Yes ☐ No ☐ Computer in bedroom? Yes ☐ No ☐			
Does your child snore? Yes ☐ No ☐			
Does your child have a limited attention span?			
Do you think your child is distractible?			
Is your student impulsive?			
Do you have concerns about your child's behavior or emotional status?			
Allergies: Does your child have medication allergies?			
Food allergies?			
Insect allergies? (bee, wasp sting)			
Environmental allergies?			
Is your child seeing an allergist? (who/when)			
Medications: Child currently taking medications? (prescription or over-the-counter)			
If yes, list medications, dose, and time taken			

HEALTHY LIFESTYLE			
Does your child eat 5 fruits or vegetables a day?			
Does your child limit TV or computer use to 2 hours per day outside of school?			
Does your child get 1 hour of physical activity every day?			
Does your child limit intake of sweet drinks? (sodas, juice, etc.)			

Signature of person completing this form_____ Date:_____

Interpreter (if applicable): _____ Date:_____

Reviewed by Nurse:_____ Date:_____