PRESCHOOL HEALTH HISTORY FORM

_____	_____	_____
Child's name	**Birth Date**	**Parent/Guardian Name**

This information will help us get to know your child better. It will be kept confidential. Please circle the correct answer.

PREGNANCY AND BIRTH

1. Yes No Were there any problems with pregnancy or your child's birth?
2. Yes No Was his/her birth weight under 5 ½ pounds?
3. Yes No Did the baby have any problems in the hospital?

MEDICAL PROBLEMS

4. Yes No Has your child ever been in the hospital overnight?
5. Yes No Is your child taking any medicine?
6. Yes No Any allergies, reactions to medicine, insects, or DTP or other shots?
7. Yes No Has your child had asthma or wheezing?
8. Yes No Does your child have a speech or hearing problem?
9. Yes No Has your child had more than two ear infections per year?
10. Yes No Has your child had tonsillitis?
11. Yes No Does your child have trouble with his eyes or seeing?
12. Yes No Has your child ever had a bladder or kidney infection?
13. Yes No Does he/she experience burning when urinating?
14. Yes No Does your child have seizures, fits, or shaking spells?
15. Yes No Have you ever been told your child has a heart murmur?
16. Yes No Is your child able to play as hard as other children?
17. Yes No Has your child ever had a bumpy or swollen reaction to a TB test?
18. Yes No Has your child ever been with anyone with TB?
19. Yes No Has your child ever had worms?
20. Yes No Does your child scratch his/her genital area?
21. Yes No Is his/her bottom or genitals sore?

22. Yes No Is your child a hemophiliac (free bleeder)?
23. Yes No Is your child on a heart monitor?
24. Yes No Does your child have tubes in his/her ears?

GENERAL DEVELOPMENT

25. Yes No Does your child get along well with other children?
26. Yes No Is he/she usually happy?
27. Yes No Does your child have any special problems not indicated above?
28. When was the last time your child saw a doctor? _____

EXPERIENCE WITH OTHERS

29. What are some of the ways in which the child plays at home? _____

_____

30. Does he play with children from other families? _____
31. Does he usually get his way with other children? _____
32. Is the entire family together for any time of the day?_____

EATING HABITS

33. At what time does the child eat: Breakfast? _____Dinner? _____Supper? _____
    Between meal snack? _____
34. Yes No Does he feed himself?
35. What is his general attitude toward eating?_____
36. If he refuses to eat, how is this handled and by whom? _____

_____

37. Favorite foods _____
38. Disliked foods_____
39. Foods she is allergic to _____Symptoms _____

_____

SLEEP HABITS

40. Has room alone ____Shares with other children____ Rooms with parents_____
41. At nights sleeps from _____to _____ Average hours of nap? _____
42. Attitude toward going to bed? _____
43. If there is any difficulty, how is this handled? _____

    _____
44. Habits associated with going to bed _____
45. Does the child wet the bed? _____ At nap? _____ At night? _____
46. If so, how is this problem handled? _____

    _____

TOILET HABITS

47. Time at which child is taken to the bathroom? _____
48. Does he go by himself? ____ Time of bowel movement_____ Regular? _____
    Constipated? _____
49. Does he/she tell you when they need to go to the toilet and go willing?

    _____
50. Can he/she manage clothes at the toilet? _____
51. What word does he use for urinating? _____
52. What word is used for BM? _____

SPEECH AND PHYSICAL GROWTH

53. Does he talk well? _____ Fairly well _____ Not very well ____ Not at all ____
54. Does anyone read to him? _____How Often: _____
55. At what age did he creep? _____ Crawl: _____ Walk? _____
56. Would you describe your child as:
    a. active or quiet
    b. thin, average, or heavy weight
    c. short, average, or tall
    d. friendly or unfriendly?
57. Any other information we should know about your child? _____

    _____

    _____