



# Health History Check List

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Parent's Name \_\_\_\_\_

The information below will help SHADES of Development provide the best possible care for your child's special needs. Please include any pertinent information, not discussed in the questions below, that may assist us with your child's care. Circle the correct answer.

## Pregnancy and Birth

- Yes No 1) Were there any problems with the pregnancy or birth of your child? \_\_\_\_\_
- Yes No 2) Was his/her birth weight under 5 1/2 pounds?
- Yes No 3) Did your baby have any problems in the hospital? \_\_\_\_\_

## Medical Information

- Yes No 4) Has your child ever been hospitalized overnight? If yes, why? \_\_\_\_\_
- Yes No 5) Does your child have asthma or wheezing?
- Yes No 6) Does your child have speech or hearing problems?
- Yes No 7) Has your child had more than two ear infections in one year?
- Yes No 8) Has your child had tonsillitis?
- Yes No 9) Does your child have trouble with his/her eyes or with seeing?
- Yes No 10) Does your child have seizures, fits, or shaking spells?
- Yes No 11) Has your child had a bladder or kidney infection?
- Yes No 12) Does he/she have burning when urinating?
- Yes No 13) Have you ever been told that your child has a heart murmur?
- Yes No 14) Is your child able to play as hard as other children?
- Yes No 15) Has your child ever had a bumpy or swollen reaction to a TB test?
- Yes No 16) Has your child ever been exposed to TB?
- Yes No 17) Has your child ever had worms?
- Yes No 18) Does your child have any type of problem with his/her genital area? \_\_\_\_\_
- Yes No 19) Does your child have any bladder control problems?
- Yes No 20) Has your child ever been tested for ADD or ADHD?
- Yes No 21) Has your child ever been diagnosed with ADD or ADHD?
- Yes No 22) Is your child currently taking any type of medication? If so, what? \_\_\_\_\_
- Yes No 23) Is your child a hemophiliac, free bleeder?
- Yes No 24) Does your child have any allergies or reactions to medicine, insects, food, sunscreen etc? If so, what? \_\_\_\_\_
- Yes No 25) Is your child on a heart monitor?
- Yes No 26) Does your child have tubes in his/her ears?

## Older Girls

- Yes No 27) Has your daughter began her menstrual cycle? If yes, how old was she when she began?
- Yes No 28) Does she have any problems with her menstrual cycle?

## General Development

- Yes No 29) Is your child in special education classes at school?
- Yes No 30) Does your child get along with other children?
- Yes No 31) Is your child usually happy?
- Yes No 32) Does your child have any special problems not listed above? If so, list on the back.
- 33) When was your child's last doctor visit? Month \_\_\_\_\_ Year \_\_\_\_\_