

Washtenaw County Head Start- Child Health History

Child's Name _____ Date of Birth _____ Female Male
First Last

Person completing history _____ Relationship to child _____

Pregnancy/Birth History (if you are not the parent answer the following questions to the best of your knowledge)

1. Did the mother receive medical care throughout the pregnancy of this child?
 Yes No
Name of Obstetrician/Clinic _____
Obstetrician/Clinic Address _____
2. Did the mother have any problems with the pregnancy?
 Yes, please explain _____
 No
3. Did the mother smoke during pregnancy?
 Yes No
4. Did the mother drink any alcohol during pregnancy?
 Yes No
5. Did the mother take any prescribed drugs or other during pregnancy?
 Yes No
6. Were there any problems during labor or delivery?
 Yes, please explain _____
 No
7. Was the baby born full term (40 weeks)? Birth Weight ____ lbs. ____ oz.
 Yes
 No, if not, number of weeks _____
8. Did the baby have any problems after birth?
 Yes, please explain _____
 No
9. Is the mother pregnant now?
 Yes No

Hospitalization

10. Has this child ever been hospitalized for a serious illness or surgery?
 Yes, please explain _____
 No

Health Concerns

11. Does your child have any of the following (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Vision/Eye Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Lead Poisoning |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Stool/Bowel Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Chicken Pox (date: _____) |

If you checked any of the above, please explain _____

12. Has your child had any dental problems?

- Yes, please explain _____
- No

13. Does your child wear glasses?

- Yes
- No

14. Does your child take any medication(s) or herbal remedies regularly?

- No
- Yes, please list.
- _____
- _____

15. Does your child have a healthcare provider?

- Yes, Name _____
- No

16. Does your child have a dentist?

- Yes, Name _____
- No

17. Do you have any concerns about your child's health or development?

- Yes, please explain _____
- No

18. Does your child spend time with any smokers on a regular basis?

- Yes, please explain _____
- No

Signature Date