# HEALTH HISTORY

1. Name of Child_____Birthdate_____

2. **Pregnancy, Birth and Development**

| | Circle One | |
|---|---|---|
| A. Were there any difficulties during pregnancy, labor or delivery? | Yes | No |
| If yes explain_____ | | |
| B. Was this child carried for a full nine months? | Yes | No |
| C. Birth Weight was _____lbs. _____oz. | | |

Did this child:

| | | |
|---|---|---|
| D. Have any trouble starting to breathe after birth? | Yes | No |
| E. Have any problems in the hospital after birth? | Yes | No |
| F. Sit alone before 7 months of age? | Yes | No |
| G. Walk alone before 15 months of age? | Yes | No |
| H. Say words by 1 1/2 years of age? | Yes | No |

I. Check any of the following which has occurred with this child

_____Sleeping problem _____Eating Problem
_____Soiling or Wetting problem _____Thumbsucking problem
_____Excessive Drooling_____Coordination Problem

3. **Illnesses and Accidents**

Has this child:

| | | |
|---|---|---|
| A Had more than one ear infection each year? | Yes | No |
| B. Had more than two throat infections each year? | Yes | No |
| C. Had a hearing problem? | Yes | No |
| D. Had a vision problem? | Yes | No |
| If yes, when were they last fitted for glasses?_____ | | |
| E. Had allergy problems, such as eczema, hives, wheezing or asthma? | Yes | No |
| F. Had frequent colds, sinus infections or hayfever? | Yes | No |
| G. Been on any routine medication? | Yes | No |
| H. Had any serious reactions to any medicine or injections? | Yes | No |
| I. Had any difficulty passing urine? | Yes | No |
| J. Ever had convulsions? | Yes | No |
| K. Had a weight problem? | Yes | No |
| L. Had any serious accidents? | Yes | No |
| M. Been hospitalized for serious illnes or accidents? | Yes | No |

**Please explain any "yes" answers (use back of sheet if necessary)**

4. **Family Health**

Do any other family members have any serious health problems? Yes No

5. **Additional Health Concerns**

Please list any additional health concerns or physical limitations of this child.

_____
_____
_____
_____

Filled out by _____Date_____