

GENERAL HEALTH INFORMATION

Please complete form in its entirety.

CHILD'S NAME: _____ Gender: _____ DOB: _____

CENTER: _____ Is your child in the WIC program? Yes No

Person Interviewed: _____ Relation to Child: _____

FAMILY INFORMATION (Please complete for family and household members):

	BIRTH	LIVES W/ CHILD		FAMILY MEMBERS
	DATE	YES	NO	HEALTH PROBLEMS
Father:				
Mother:				
Brothers & Sisters (oldest first)				
1.)				
2.)				
3.)				
4.)				
5.)				
Other (specify relationship)				
1.)				
2.)				
3.)				

DIETARY HABITS (Including cultural preferences)

1. What foods does your child expecially like? _____
2. Are there any foods your child dislikes? _____
3. Does your child take vitamins and mineral supplements? Yes No If yes, specify kind: _____
(b) Do they contain iron? Yes No (c) Do they contain fluoride? Yes No (d) Were they prescribed? Yes No
4. Is there any food your child should not eat for medical, religious, or personal reasons? Yes No
If yes, please list foods: _____
5. Is your child on a special diet? Yes No (a) What kind? _____
6. Has there been a big change in your child's appetite in the last month? Yes No
7. Does your child take a bottle? Yes No
8. Does your child eat or chew things that aren't food? Yes No _____
9. Does your child have trouble chewing or swallowing? Yes No _____
10. Does your child often have: (a) Diarrhea Yes No (b) Constipation Yes No
11. The food pyramid gives guidelines for the recommended number of servings per day of each food group, as listed below. Please note yes or no, if you think your child on an average eats the recommended servings per day.

a. Bread, cereal, rice & pasta group----- 6 to 11 servings	Yes _____	No _____
b. Fruit group ----- 2 to 4 servings	Yes _____	No _____
c. Vegetable group ---- 3 to 5 servings	Yes _____	No _____
d. Milk, yogurt, & cheese group --- 2 to 3 servings	Yes _____	No _____
e. Meat, poultry, fish, dry beans, eggs, & nut groups ----- 2 to 3 servings	Yes _____	No _____
f. Fats, oils, sweets ---- sparingly	Yes _____	No _____
12. Circle how many times a week your child eats one or more of the following foods:

a. Oranges, grapefruits, tomatoes -- fruit or juice	0 1 2 3 4 5 6 7
These fruits are a valuable source of Vitamin C and are served daily at the HS Ctr.	
b. Greens, carrots, broccoli, winter squash, sweet potatoes, pumpkin	0 1 2 3 4 5 6 7
These foods are a valuable source of Vitamin A and are served a minimum of three times a week at the HS Ctr.	
13. Do you have any specific concerns about what your child eats? _____

Date: _____ Signature of Interviewer: _____

CHILD HEALTH RECORD:

HEALTH HISTORY 2A

TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW.

CHILD'S NAME: _____ **SEX:** _____ **BIRTHDATE:** _____

CENTER: _____ **PERSON INTERVIEWED:** _____ **Relation:** _____

PREGNANCY / BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. Did Mother have any health problems during this pregnancy or during delivery?			
2. Did Mother visit physician fewer than 2 times during pregnancy?			
3. Was child born outside of a hospital?			
4. Child born more than 3 weeks early or late?			
5. What was child's birth weight?			lbs. oz.
6. Was anything wrong with child at birth?			
7. Anything wrong with child in the nursery?			
8. Did child or mother stay in hospital for medical reasons longer than usual?			
9. Is mother pregnant now?			(If yes, ask about prenatal care, or schedule time to discuss prenatal care arrangements).
HOSPITALIZATIONS AND ILLNESS	YES	NO	
10. Has child ever in hospital / had surgery?			
11. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)?			
12. Has child ever has a serious illness?			
HEALTH PROBLEMS	YES	NO	EXPLAIN (Use additional sheets if needed)
13. Does child have frequent ____ Sore Throat; ____ Urinary Infections or trouble urinating; ____ Stomach Pain, Vomiting, Diarrhea?			
14. Does child have difficulty seeing (Squint, cross eyes, looks closely at books)?			
15. Is child wearing (or should wear) glasses?			(If "yes") Was checkup more than one year ago?
16. Does child have problems with ears/hearing (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?			
17. Ever notice child scratching his/her behind (rear end, anus) while asleep?			
18. Has child ever had a convulsion or seizure? Is child taking medicine for seizures?			If "yes" ask: When did it last happen? _____ What medicine?
19. Is child taking any medicine now? (Special consent form must be signed for Head Start to administer any medication).			What medicine? _____ (If "yes") will it need to be given while child is at H.S.? How often?
20. Is child now being treated by a physician or a dentist? Yes ____ No ____			Name: _____ For what?
21. Has child had: ____ Boils ____ Chickenpox ____ Eczema ____ German Measles ____ Measles ____ Mumps, ____ Scarlet Fever ____ Whooping Cough? , ____ Hives			
22. Does your child have any other communicable disease?			
23. Has child had: ____ Asthma, ____ Diabetes, ____ Bleeding Tendencies, ____ Epilepsy, ____ Heart/ blood vessel disease, ____ Liver Disease, ____ Rheumatic fever, ____ Sickle Cell disease?			
24. Does child have any allergy problems (rash,itching,swelling,difficulty breathing, sneezing)? a. When eating any food..... b. When taking any medication.... c. When near animals, furs, insects, dust, etc?			What foods? What medicine? What things? How does child react?
25. (If any "yes" answers to questions 14,16,18,22 23,24 ask) Do any of the conditions we've discussed so far get in the way of the child's everyday activities: Did a doctor or other health professional tell you the child has this problem?			Describe how: When?
26. Are there any conditions we haven't talked about that get in the way of the child's everyday activities? b. Did a doctor or other health professional tell you the child had this problem?			Describe: When?

SIGNATURE OF INTERVIEWER: _____

DATE: _____

CHILD HEALTH RECORD:

FORM 2B, HEALTH HISTORY (Continued)

CHILD'S NAME: _____ **SEX** _____ **BIRTHDATE:** _____

CENTER: _____ **DATE:** _____

PERSON INTERVIEWED: _____ **RELATIONSHIP:** _____

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL DEVELOPMENT				
These questions will help us understand your child better and know what is usual for him/her and what might not be usual that we should be concerned about:				
27. Can you tell me one or two things your child is interested in or does especially well?				
28. Does your child take a nap? Yes___ No___ If "yes" describe when and how long.				
29. Does your child sleep less than 8 hours a day or have trouble sleeping (such as being fretful, having nightmares, wanting to stay up late)? Yes___ No___ If "yes" describe arrangements (own room, own bed, & etc).				
30. How does your child tell you he/she has to go to the toilet?				
31. Does your child need help in going to the toilet during the day or night, or does your child wet his/her pants? Yes___ No___ If "yes" please describe.				
32. How does your child act with adults that he/she doesn't know?				
33. How does your child act with a few children his/her own age?				
34. How does your child act when playing with a group of other children?				
35. Does your child worry a lot, or is he/she very afraid of anything? Yes___ No___ If "yes", what things seem to cause him or her to worry to be afraid?				
36. Children learn to do things at different ages. We need to know what each child already can do or is learning to do at this time. We also need to know what areas they need help in so we can fit our program to meet their needs.				
Indicate whether or not the child has accomplished the milestones by the expected age (listed age) by circling Y (yes), N (no), or UK(unknown).				
Y	N	UK	2 mo	social smile, eye contact, cooing
Y	N	UK	4 mo	hands together in midline
Y	N	UK	8 mo	transferring objects, sitting alone
Y	N	UK	9 mo	babbling
Y	N	UK	12 mo	cruising, creeping, reach, grasp, release objects
Y	N	UK	15 mo	single words, walking
Y	N	UK	18 mo	pointing response
Y	N	UK	24 mo	two words together, pushing, pulling, carrying objects while walking
Y	N	UK	3 yr	toilet trained(day), gender identity, uses 3-5 word sentences
Y	N	UK	4 yr	takes turns, counts 3-8 objects
Y	N	UK	5 yr	dresses self, names 2 coins
37. Does your child have any difficulties saying what he/she wants to do or do you have any trouble understanding your child? Yes___ No___ If "yes" please describe.				
38. Children sometimes get cranky or cry when they're tired, hungry, sick, and etc. Does your child often get cranky or cry at other times, when you can't figure out why? Yes___ No___ If "yes" can you tell me about that? When this happens, what do you do about it to help the child feel better?				
39. Have there been any big changes in your child's life in the last six months? Yes___ No___ If "yes" please describe.				
40. Are you or your family having any problems now that might affect your child? Yes___ No___ If "yes" please describe.				
41. Is there anything else you would like us to know about your child? Yes___ No___ If "yes" please describe				

SIGNATURE OF INTERVIEWER: _____ **DATE:** _____

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