Health History -Infants/Toddlers

Child's Name ____

Child's Date of Birth __________________________

Please circle Y for **yes**, N for **no** for each question listed.

A. Health

Y N 1.Does your child seem well most of the time?

Y N 2. Is your child taking any medications now (including aspirin, laxatives, vitamins, etc.)?

If YES, What? ________________________

How often? __________________________

Y N 3. In a year has your child had as many as three ear infections?

Y N 4. Are you concerned with your child's hearing?

Y N 5. In a year, does your child have more than three colds or sore throat infections with fever?

Y N 6. Are you concerned about your child's eyes or vision?

Y N 7. Has your child been seen by a medical specialist?

If YES, Who? _________________________

For What? ___________________________

Y N 8. Does your child have any disabilities?

Y N 9. Other illness/diseases?

Y N 10. Has your child been hospitalized within the past year?

Y N 11. Has your child had any serious accidents or poisonings?

Y N 12. Does your child chew unusual things, such as pencils, chalk, crib, window ledges, paint chips, plaster, or hair?

13. Has your child had any of the following:

Y N Premature birth
Y N Birth injury or defect
Y N Trouble breathing at birth
Y N Convulsions/seizures
Y N Allergies: (please circle) Eczema Hives Drug/food intolerance Hay Fever

Wheezing Asthma Insect stings Other:

B. Developmental History

14. How do you comfort your child?

15. What are your child's favorite toys?

What are your child's favorite activities?

16. What language is spoken in your home?

C. Sleeping

Y N 17. Do you have any special ways of helping your child to sleep?

What?

Y N 18. Does your child cry when going to sleep?

What is your child's present sleeping schedule?

Nighttime: From __________ to ______________

A.M. Nap: From __________ to ______________

P.M. Nap: From ___________ to ______________

D. Feeding

19. Is your baby breast-fed? **Yes** or **No** Bottle-fed? **Yes** or **No**

*Type of bottle: ___________________ *Type of nipple _____________

*Type of formula __________________________

How many ounces taken between burps?

20. What is your child's present eating schedule (specify amount and time for milk/formula, juice, food)

Breakfast ___________________________________

A.M. Supplements ___________________________

Lunch _____________________________________

P.M. Supplements ____________________________

Y N 21. Does your child have feeding problems?
What?

E. Toileting

22. How frequently does your child have a bowel movement?

23. Appearance of BM:

Y N 24. Is your child toilet trained?

25. What word does your child use for:
Urination:
Bowel movement:

Y N 26. Do they use a potty chair?

Y N 27.Does your child frequently have diaper rash? If yes, how would you like us to treat your child's diaper rash?

*INFANTS ONLY

Parent's Signature: _________________________________

Date: ______________________