Mounds View
PUBLIC SCHOOLS

EARLY CHILDHOOD HEALTH HISTORY

Child's Name:	Birth Date: Language spoken at home:
Date Completed: Completed by: Relationship to child:	Phone: H ________________ W ________________ C ________________ Address:

Family Information: Please list family/household members including adults and children.

Name	Relationship to Child	Birth date	Male or Female	Lives at home

Please share some basic information about your child's health.

Pregnancy Labor/Delivery Newborn History Adoption	Tell us about any problems or concerns during pregnancy. Name/s and frequency of prescription medication, tobacco/alcohol/chemical use during pregnancy: Tells us about any problems or concerns during labor or birth. Did child go home with mother? ______ Other concerns? Age of child when adopted ________________ Country of Birth: ________________
Developmental Milestones	At which age were developmental milestones reached (approximate ages)? Sat Alone: ______ Stood with support: ______ Walked Alone: ______ Spoke First Words: ______ Talked in sentences: ______ Became toilet trained: ______
Health Conditions or Medical Diagnoses	Tell us about any diagnosed physical, emotional or behavioral conditions or diagnoses your child may have. What other immediate or extended family members have or have had similar conditions? Does your child take any medication for a health condition? ______
Childhood Illness	Tell us about any childhood illness your child has had (e.g., Chicken pox, Pertussis, strep infections, RSV) and how they were treated.

Pg. 2	Child's name:
Injury	Tell us about any significant injuries your child has had and how they were treated.
Ears/Hearing	Did your child have a newborn hearing screening in the hospital? ______ Results? Has your child's hearing been tested since by a health care provider? ______ Results? Tell us about any problems ear or hearing problem your child may have. How have any problems been treated? • With Medication? ______ When: ______ • With PE tubes? ______ When: ______ Have problems affected your child's hearing? ______ How?
Eyes/Vision	Tell us about any eye or vision problems your child may have. Has your child's vision been tested by a health care provider? ______ Does your child wear glasses or have any other treatment for eye or vision problems? ______
Allergy	Tell us if any allergies your child may have. Tell us which if any allergies could be life threatening. ______________________________ Has your child had a severe (anaphylactic) allergic reaction? _______ When? _______________ Does your child need emergency medication such as an Epipen? ______ What special food needs does your child have because of allergy?
Breathing	Tell us about any breathing problems your child has. How often does your child need medication for breathing?
Cardiac, Heart, Blood	Tell us about any heart or blood problems your child has.
Stomach Bowel Bladder	Tell us about any frequent problems your child has had with stomach aches, digestion vomiting, constipation or diarrhea. Tell us about any frequent kidney or bladder problems your child has had beyond developmental age.
Neurological Skeletal Muscular	Tell us about any problems your child may have with: • Seizures or staring spells • Body weakness or unexplained motor movements
Lead	Has your child had a blood test for lead? ______ Was the lead level too high? ______

Pg. 3	Child's name:
Growth	Tell us about any concerns you have about your child's growth.
Eating Habits	Tell us about any concerns you have about your child's eating habits.
Sleep	Tell us about your child's usual sleeping patterns. Bedtime: ______________ Awakens at: ______________ Please describe any problems that affect your child's sleep.
Activity	Tell us about any activity restrictions your child may have. Does your child seem to have more or less energy than you would expect? ______ Describe:
Medications	Tell us what medications if any your child takes every day. Tell us what medications if any your child takes "as needed".
Family Stressors	Tell us about any family stressors that affect your child.
Safety	Does your child use a car seat or booster seat? ______ Is it in the front or back seat? ___________ Are there guns in your home? ______ How are they secured? Do you have the number for Poison Control? ______ Where is it kept? ______
Health Insurance	Tell us what type/s of health insurance your child has: ______ Private insurance, ______ Medical Assistance, ______ Minnesota Care, ______None Would you like help in getting health insurance for your child? ______
Other	Please share any other concerns you have.

Thank you for helping us better understand your child's health needs.