# CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-5 YEARS)

Child's Name:_____☐ M ☐F Birthdate:_____ Age:_____

Parent/Guardian Name(s):_____

If not married at time of birth, who has legal signing rights for this child?_____

Family Members living with child:

| Name | Relationship to child | Age | Gender |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Primary Physician:_____Date of last well child visit:_____

Primary Dentist:_____Date of last dental check-up:_____

Has your child had a comprehensive vision exam:_____Date of last vision exam:_____
*The comprehensive vision exam is performed by an optometrist or ophthalmologist.*

Does your child have health insurance? ☐ Yes ☐ No ☐ Applied

**Please check anything that applies to your child:**

☐Child has or had a diagnosis of_____. Explain:_____

Allergies: ☐None ☐Food ☐Medicine ☐Animals/insect ☐Dust/mold ☐Seasonal
Describe:_____

☐Visits to health specialist(s), hospital stays and/or surgeries ☐Head injuries (loss of consciousness?)

☐Serious injuries or illnesses, visit to Emergency Room. Reason and date:_____

☐Lead exposure, level if known ☐Trouble breathing, coughing or asthma ☐Skin problems or rashes

☐Seizures, staring spells ☐Teeth: one or more cavities ☐Eating, stomach concerns or constipation

☐Mental health concerns such as anxiety, depression or attention concerns?

☐Gets 60 minutes or more of physical activity each day TV/Video Game/Screen Time: _____hours per day

☐Has difficulty falling/staying asleep ☐Adopted, if Yes, at what age: _____
☐Foster care or out of home placement

☐Problems during pregnancy or birth?

☐At birth, stayed in the hospital longer than mother. Reason: _____

# Weeks at birth _____ Child's birth weight ___lbs. ____oz.

Is it possible that before you knew you were pregnant you used medications, alcohol, cigarettes, or street drugs?
☐Yes ☐No

**Please check any Family Health problems (child's parents or siblings):**

| | | |
|---|---|---|
| ☐ Attention problems | ☐ Vision problems | ☐ Diabetes |
| ☐ Allergy | ☐ Learning Problems | ☐ Growth Problems |
| ☐ Asthma | ☐ Mental Health Disorders | ☐ Epilepsy/Seizures |
| ☐ Deafness/Hearing | ☐ Sickle Cell Anemia/Trait | ☐ Other health problems |

## CHILD'S DAILY ROUTINES

**Every day eats some foods from the food groups:**

☐5-9 servings fruits/vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas

☐2-3 servings calcium rich foods: milk, cheese, yogurt, soymilk, and tofu

☐2-3 servings iron rich foods: fish, poultry, meat, beans, legumes, eggs

☐3 or more servings: whole grains: whole wheat bread, cereal, brown rice, tortillas, crackers, pasta

☐More than one serving of sweets, fruit drinks or junk food each day

☐Yes ☐No In the past 12 months, we worried whether our food would run out before we could buy more

☐Yes ☐No In the past 12 months, the food we bought didn't last and we didn't have money to get more

## HOME SAFETY

**Current housing situation:** ☐ Renting or homeowner ☐Doubled-up with friends or family ☐Hotel or motel ☐Emergency shelter/transitional housing ☐ Unsheltered (cars, parks, and campgrounds, temporary trailer)

Does your child live or play in a home or building built before: ☐ 1978 ☐ Remodeled in last 5 years?

**Do you and /or your child use/have the following?** ☐Car seats ☐Bike helmets ☐Smoke detector ☐Carbon monoxide detector

## GROWTH AND DEVELOPMENT

**My child did NOT seem to do the following milestones at the same age as other children:**
☐rolled over ☐grasped & released toys ☐sat alone ☐crawled ☐pulled self to standing ☐threw a ball ☐caught a ball ☐walked holding on furniture ☐walked alone ☐stood on one foot with no support

☐said first word ☐became toilet trained

Are other people able to understand your child's speech? ☐Yes ☐No

Do you have concerns about your child's talking? ☐Yes ☐No

Completed by_____Relationship to child_____Date_____