Health History for Infants and Toddlers

(To be completed by parent before admission)

Child's Name: ______________________ **Birth Date:** __________ **Date:** __________

Section A: Health History:

1. Does this child seem well most of the time? .... ☐ Yes ☐ No
2. Is child taking any medicines now (including aspirin, laxatives, vitamins, etc.)? .... ☐ Yes ☐ No
   If yes, what? __________ Why? __________
3. In the last year, has this child had as many as three (3) ear infections? .... ☐ Yes ☐ No
4. Are you concerned about your child's hearing? .... ☐ Yes ☐ No
5. In the last year, has this child had more than three (3) colds or sore throat infections with a fever? .... ☐ Yes ☐ No
6. Are you concerned about your child's eyes or vision? .... ☐ Yes ☐ No
7. Has your child been seen by a medical specialist other than their regular MD? .... ☐ Yes ☐ No
   If yes, who? __________ Why? __________
8. What arrangements have you made for the care of your child should he/she become ill at the center? __________
9. Does your child have any handicaps? .... ☐ Yes ☐ No
   Describe: __________
10. Other illnesses or diseases .... ☐ Yes ☐ No
    If yes, what? __________
11. Has this child been hospitalized? .... ☐ Yes ☐ No
    Describe: __________
12. Has this child had any serious accidents or poisonings? .... ☐ Yes ☐ No
    If yes, what? __________
13. Does this child chew unusual things like pencils, chalk, cribs, window ledges, paint chips, plaster or hair? .... ☐ Yes ☐ No
14. Has your child had any of the following (please circle)?
    Premature birth Birth injury or defect Trouble breathing at birth Convulsions/seizures Head injury
    Allergies: Eczema, hives, drug/food intolerance, hay fever, wheezing, asthma, insect stings
    Describe: __________

Section B: Developmental History

1. How do you comfort your child? __________
2. What are your child's favorite toys? __________
3. What are your child's favorite activities? __________
4. What language is spoken at home? __________

Section C: Sleeping History

1. Do you have any special way of helping your child go to sleep? .... ☐ Yes ☐ No
   What? __________
2. Does your child cry when going to sleep (infants only) .... ☐ Yes ☐ No
3. What is your child's present sleeping schedule?
   Night time: From ______ To ______ ; A.M.: From ______ To ______ ; P.M.: From ______ To ______
4. Does your baby (infants only) prefer to sleep on his/her: ☐ Stomach ☐ Side ☐ Back

CONTINUED ON REVERSE SIDE

Section C: Sleeping History (Continued)

5. Does your child need a pacifier (infants only)? . . . . ☐ Yes ☐ No
6. Does your baby need a blanket? . . . . ☐ Yes ☐ No
7. Does your baby need a toy? . . . . ☐ Yes ☐ No

Section D: Feeding History

1. Is the baby breast fed (infants only) ? . . . . ☐ Yes ☐ No
2. Is the baby bottle fed (infants only) ? . . . . ☐ Yes ☐ No
3. Type of bottle (infants only)? ______________________
4. Type of formula (infants only)? ______________________
5. How many ounces taken between burps (infants only)? ______________________
6. What is your child's present eating schedule? (specify amount and time for milk, formula, juice, food, etc.)?
   Breakfast: ______________________
   A.M. supplements: ______________________
   Lunch: ______________________
   P.M. supplements: ______________________
7. Has your child had any feeding problems? . . . . ☐ Yes ☐ No
   What? ______________________

Section E: Toileting History

1. How frequently does your child have a bowel movement (B.M.)? ______________________
2. Appearance of B.M. ______________________
3. Is your child toilet trained?. . . . ☐ Yes ☐ No
4. What word does your child use for urination? ______________________
5. What word does your child use for B.M.? ______________________
6. Does he/she use a potty chair? . . . . ☐ Yes ☐ No
7. Does your child frequently have diaper rash?. . . . ☐ Yes ☐ No
8. How do you treat your child's diaper rash? ______________________

Parent's Signature: ______________________ Date: ____________