

HEALTH HISTORY

Child's Name:	Date of Birth:	Parent/Guardian:
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Medical Coverage

- Yes / No 1. Does child receive medical services through ongoing source of continuous, accessible medical care?
- Yes / No 2. Does your family have a regular doctor or a regular place to receive health services?
If yes, please answer the following:
Doctor's Name: _____
Address: _____
- Yes / No 3. Do you use the County Health Department for health care?
If yes, what city? _____ Date of last physical _____
- Yes / No 4. Do you have "regular" Medi-Cal (Blue Cross/Health Net)?
- Yes / No 5. Do you have "emergency only" Medi-Cal?
- Yes / No 6. Do you have Healthy Families (California Kids Insurance-Gateway)?
- Yes / No 7. Do you have private/other health insurance? Name of Insurance: _____

Dental Information

- Yes / No 1. Do you have dental insurance? Name of Insurance: _____
- Yes / No 2. Does the child have an Ongoing Source of Continuous and Accessible Dental Care?
Dentist Name: _____ Address: _____
- Yes / No 3. Were there any problems for the child? _____

Medical History

- Yes / No 1. Has anyone in the family ever had any serious illnesses or abnormalities? (i.e., heart disease, diabetes, tuberculosis, asthma, mental illness, substance abuse)
If yes, please explain: _____
- Yes / No 2. What was the child's weight at birth? _____
- Yes / No 3. Was there breathing difficulty for the child at birth?
- Yes / No 4. Did mother use drugs or alcohol during pregnancy? Please identify: _____
- Yes / No 5. Is your child taking any medications every day? Please identify _____
- Yes / No 6. Will medication be needed at school? If yes, please explain: _____

Has this child ever had the following illnesses? If so, please give date and explain below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Measels
<input type="checkbox"/> Mumps
<input type="checkbox"/> Chickenpox
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Respiratory
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Seizures | <input type="checkbox"/> Ear/Nose/Throat Problems
<input type="checkbox"/> Urinary/Kidney Problems
<input type="checkbox"/> Muscle/Bone Problems
<input type="checkbox"/> Anemia
<input type="checkbox"/> Blood Pressure
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> Eye Problems
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Intestinal Problems |
|---|--|--|

Comments: _____

Has your child ever had the following? If yes, please give date and explain.

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Hospitalizations
<input type="checkbox"/> Operations
<input type="checkbox"/> Serious Injuries
<input type="checkbox"/> Other Health Problems/Illnesses
<input type="checkbox"/> Allergies to Medications (i.e., penicillin, sulfa drugs) | _____

_____ |
|--|----------------------------------|

Developmental History: Did child . . .

- Focus eyes and follow light or objects with eyes by 2 months?
- Coo and Gurgle by 3 to 4 months?
- Sit alone on or before the 8th month?
- Walk alone on or before the 15th month?
- Say simple words on or before the 2nd year?
- Toilet train on or before the 3rd year?
- Mental development appear normal?

Comments:

Immunizations: Parent provided copy of: (Circle)

Yellow Immunization Card Private Doctor Record Other _____

Lead Poisoning Screening

- Yes / No 1. Is paint peeling or chipping on any part of your house?
- Yes / No 2. Is your house being remodeled?
- Yes / No 3. Has your child or anyone in your family been treated or monitored for lead poisoning (i.e. blood lead > 10)?
- Yes / No 4. Does your child live with someone whose job or hobby involved exposure to lead (i.e. painting, soldering, automobile battery manufacturing or recycling, vehicle radiator repair, auto painting, or stained glass work)?
- Yes/No 5. Do you or anyone else who lives with or cares for your child use Azarcon, Greta, Rueda, Coral, Alcaron, Liga, or Maria Luisia?
- Yes/No 6. Do you use pottery (ceramics, earthenware) that is old or has been bought outside the US for cooking, eating, drinking, or storing food?
- Yes/No 7. Does your family buy canned food or packed candies from other countries?
- Yes/No 8. Does your child eat dirt or clay or other non-food items?
- Yes/No 9. Does your child or family frequently travel outside the US?

Asthma/Allergy Screening

- Yes/No 1. Has your child ever been diagnosed by a medical professional as having asthma?
 Date of diagnosis _____
 How many episodes per year? _____
 If asthma/allergy is seasonal, at what time of the year do the episodes most often occur?

 Is it controlled? _____ How? _____
- Yes/No 2. Has your child experienced any of the following due to asthma. Please check those that apply.
 Treatment in ER If yes, then # of times: _____
 Hospitalizations If yes, then # of times: _____
- Yes/No 3. Have you ever given your child any medications for asthma?
 If yes, please check all that your child has used in the last year.
 Albuterol Intal Ventolin Pedia Pred
 Tedral Prelone Proventil Primitine Mist
 Marax Quiboron Other: _____
- Yes/No 4. Does your child use a Nebulizer or Inhaler?
- Yes/No 5. How many colds does your child have in a year? _____
- Yes/No 6. Does your child suffer from hay fever or eczema?
- Yes/No 7. Is your child allergic to any of the following?
 If yes, please check all that apply.
 Animals Birds Grass Pollen
 Flowers Trees Dust Weather Changes
 Perfume Smoke Other: _____
- Yes/No 8. Does anyone in the household smoke? (i.e. home/car)

(circle one)

Completed by: Parent/Guardian/Staff _____

Reviewed by _____

Date _____