Washtenaw ISD
A REGIONAL EDUCATIONAL SERVICE AGENCY

Washtenaw ISD Early Childhood Programs
Child Health History

CHILD NAME:	DATE COMPLETED:
DOCTOR/PRACTICE:	HEALTH INSURANCE: YES NO
DENTIST/PRACTICE:	INSURANCE TYPE: Medicaid Private

Preliminary Questions

- How much did this child weigh at birth? _____ lbs. _____ oz
- Were there any problems with this child immediately after birth? **If yes,** please explain: _____

  _____
- Is your child taking any medications every day? **If yes,** please explain: _____

  _____
- Has anyone in the family ever had any serious illnesses or abnormalities? (e.g. heart disease, diabetes, cancer, asthma, tuberculosis, etc.) **If yes,** please explain: _____

  _____

Has this child ever had the following? (If "Yes", write date and explain)

- Allergies (food, drug, environmental, bee stings)..... ☐ No ☐ Yes _____
- Diabetes..... ☐ No ☐ Yes _____
- Chickenpox ..... ☐ No ☐ Yes _____
- Hearing Problems ..... ☐ No ☐ Yes _____
- Vision/Eye Problems or Eye Glasses..... ☐ No ☐ Yes _____
- High Lead Levels..... ☐ No ☐ Yes _____
- Frequent Diarrhea/Constipation/Vomiting..... ☐ No ☐ Yes _____
- Seizures/Epilepsy..... ☐ No ☐ Yes _____
- Anemia/Sickle Cell ..... ☐ No ☐ Yes _____
- Ear/Nose/Throat Problems ..... ☐ No ☐ Yes _____
- Urinary/Kidney Problems/Bed Wetting ..... ☐ No ☐ Yes _____
- Muscle/Bone Problems ..... ☐ No ☐ Yes _____
- Heart Disease/Heart Murmur/Rheumatic Fever..... ☐ No ☐ Yes _____
- Pneumonia/Tuberculosis..... ☐ No ☐ Yes _____
- Skin Problems/Eczema ..... ☐ No ☐ Yes _____
- Hospitalizations/Operations..... ☐ No ☐ Yes _____
- Serious Injuries (broken bones, burns, head injuries)... ☐ No ☐ Yes _____
- Other Health Problems/Illnesses..... ☐ No ☐ Yes _____

Developmental History

Did Your Child…

- Sit alone on or before the 8th month?..... ☐ Yes ☐ No _____
- Walk alone on or before the 15th month? ..... ☐ Yes ☐ No _____
- Toilet trained on or before the 3rd year? ..... ☐ Yes ☐ No _____
- Receive therapy/speech therapy? Early On? Other? ☐ Yes ☐ No, list: _____

OVER

Asthma Screening

- Has your child ever been diagnosed by a medical professional as having asthma? ☐ No ☐ Yes
  a) Date of diagnosis: _____
  b) Is it seasonal? ☐ No ☐ Yes
  c) At what time of year do the episodes most often occur? _____
  d) Is it well controlled? ☐ No ☐ Yes, how? _____
- Has your child experienced any of the following due to asthma?
  Treatment in Emergency Room? ☐ No ☐ Yes, how many times? _____
  Hospitalizations? ☐ No ☐ Yes, how many times? _____
- Have you ever given your child medications for asthma? ☐ No ☐ Yes, check all your child has used in the last year?
  ☐ Albuterol ☐ Intal ☐ Ventolin ☐ PediaPred ☐ Tedal ☐ Prelone
  ☐ Proventil ☐ Marax ☐ Quiboron ☐ Primatine Mist ☐ Other: _____
- Does your child use a Nebulizer or Inhaler? ☐ No ☐ Yes
- Does anyone in the family smoke in the home and/or in the car? ☐ No ☐ Yes

Parent/Guardian Signature _____ Date _____

Staff Signature _____ Date _____