CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-6 YEARS)

Child's Name:_________________________________ __M __F Birthdate:__________Age________

(For office use only)

MARSS other ID ___________Languages spoken at home_______________________________________

Parent/Guardian Name (s): ____

Person completing form:________________________Date______________________________________

How often does your child see a doctor or nurse ? _______Date of last well child visit: __________________

How often does your child see a dentist ? _____________Date of last dental check up __________________

Date of your child's most recent comprehensive vision (eye) exam, if your child received one. _____________

The comprehensive vision exam is performed by an optometrist or ophthalmologist.

Does your child have health insurance? _Yes __ No __ Applied

Please check the boxes if you or your child use, if any:

______ Early Childhood Family Education (ECFE)
______Early Childhood Special Education (ECSE)
______ Follow Along Program
______ Parenting Education
______ Park and Rec programs
______ Child &Teen Checkups
______ School Readiness
______ Private Preschool
______ Head Start
______ Foster Care
______ Child Care Center
______ Family/neighbor care
______ Library
______ WIC
______ Food Shelf

HEALTH

Please check any concerns that apply to your child and describe:

______ Allergies__ foods __ medicines ___animals/ insects __ dust/mold__ seasonal___________________
______ Takes medicines, herbs and/or vitamins _______________________________________
______ Visits to health specialist(s), hospital stays and/or surgeries ___________________________
______ Serious injuries or illnesses, visit to Emergency Room. Reason and date: ____________________
______Head injuries (loss of consciousness?) ___________________________________
______Lead poisoning, level if known: ____
______Trouble breathing, coughing or asthma____
______Skin problems or rashes____
______Seizures, staring spells____
______Vision problem or wears glasses____
______Ear (PE) tubes or hearing problems____
______Teeth: one or more cavities____
______Eating, stomach concerns or constipation_______________________________________
______Mental health concerns such as anxiety, depression or attention concerns?________________
______Adopted, if Yes, at what age____
______ Problems during pregnancy or birth? ____
______ Born more than 3 weeks early or late. ______# weeks at birth. Child's birth weight_______________
______ At birth, stayed in the hospital longer than mother, reason: ______________________________
______ Is it possible that before you knew you were pregnant you took medications, alcohol, cigarettes, or street drugs? ____
______Please list any other concerns____

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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

_____ Sleeps at __ pm Wakes up at __ am
_____ Has difficulty falling / staying asleep
_____ Takes a nap: from _____ to _____
____ Gets 60 minutes or more of exercise each day
____ Is NOT able to/does NOT get 60 minutes of exercise
____ TV/Video Game/Screen Time: ____ hours per day

Every day eats some foods from the food groups:

___ 5-9 servings fruits /vegetables: oranges, apples, bananas, mangos, berries, spinach, corn, peas
___ 3 servings calcium rich foods: milk, cheese, yogurt, soymilk, tofu
___ 2-3 serving 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
___ 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 __yes __no

HOME SAFTEY

Current housing situation: __ housed (rental or homeowner) __staying with friends or family
__staying in emergency shelter/transitional housing __ staying in hotel or motel

Does your child live or play in a home or building built before: __1978 __remodeled in last 5 years?

Does anyone at home or who cares for your child: __ use tobacco/smoke __ use alcohol __ have a gun

Do you have concerns that your child is exposed to: ___violence __street drugs __unsafe conditions_

Do you and /or your child use/have the following:
_____car seats_____bike helmets and safety equipment ____ smoke detector _____ carbon monoxide detector

LEARNING

_____ My child learned to do things at the same age as other children (sit, stand, walk, become toilet trained, etc)

If not, please explain:____

My child needs help with: __ toileting __ activity/mobility__ dressing __ nutrition/eating __ other

Please check any of the following:

__Says numbers 1 to 10
__Has trouble speaking or hard to understand
__Has trouble being understood by others
__Seems clumsy when using hands
__Understands other people
__Able to follow directions
__Plays in a variety of ways
__Walks or runs poorly (falls)