CHILD'S HEALTH HISTORY CHECKLIST

Child's Name	Birth Date	Parent or Guardian's Name

The answers to these questions will help us to know if your child has any medical problems. We need this information in case he/she should become ill and we would be unable to reach you right away. Please circle the appropriate answer. We will go over the checklist with you when you have finished.

Pregnancy and Birth

Yes	No	1.	Were there any problems with pregnancy or your child's birth?
Yes	No	2.	Was his/her birth weight under 5 ½ pounds?
Yes	No	3.	Did the baby have any problems in the hospital?

Medical Problems

Yes	No	4.	Has your child ever been in the hospital overnight?
Yes	No	5.	Is your child taking any medicine?
Yes	No	6.	Any allergies or reactions to medicine, DTP, or other shots or illnesses?
Yes	No	7.	Has your child had asthma or wheezing?
Yes	No	8.	Does your child have speech or hearing problems?
Yes	No	9.	Has your child had more than two ear infections in a year?
Yes	No	10.	Has your child had tonsillitis?
Yes	No	11.	Does your child have trouble with his/her eyes or seeing?
Yes	No	12.	Has your child had a bladder or kidney infection?
Yes	No	13.	Does he/she have burning when urinating?
Yes	No	14.	Does he/she have seizures, fits, or shaking spells?
Yes	No	15.	Have you ever been told your child has a heart murmur?
Yes	No	16.	Is your child able to play as hard as other children?
Yes	No	17.	Has your child ever had a bumpy, swollen reaction to the TB skin test?
Yes	No	18.	Has your child ever been with anyone that has TB?
Yes	No	19.	Has your child ever had worms?
Yes	No	20.	Does your child scratch his/her genital area?
Yes	No	21.	Is his/her bottom or genitals red or sore?
Yes	No	22.	Is your child a hemophiliac (free bleeder)?
Yes	No	23.	Is your child on a heart monitor?
Yes	No	23.	Does your child have tubes in his/her ears?

Older Girls

Yes	No	24.	How old was your daughter when she had her first period?
Yes	No	25.	Does she have any problems with her period?

General Development

Yes	No	26.	Is your child in a special education class in school?
Yes	No	27.	Does your child get along with other children?
Yes	No	28.	Is he/she usually happy?
Yes	No	29.	Does your child have any special problems not indicated above?
Yes	No	30.	When did your child last see a doctor? Month: _____ Year: _____