

Preschool Health History
(To be completed by parent before admission)

The purpose of securing this information about your child is to help the Visitation Childcare Center staff better understand your child and more easily meet your child's needs.

Child's Name: _____ Birth Date: _____ Date: _____
Nickname: _____

Section A: Health History:

1. Does this child seem well most of the time? Yes No
2. In a year, has this child had as many as three episodes of ear trouble? Yes No
3. In a year, does this child usually have more than three colds or sore throat infections with fever? Yes No
4. Does this child have trouble getting rid of severe coughs? Yes No
5. Does this child complain frequently of headache, leg ache, stomachache, or other pain?..... Yes No
6. Has this child had trouble with his/her eyes or vision?..... Yes No
7. Is child's appetite usually good?..... Yes No
8. Does this child chew unusual things such as pencils, cribs, window ledges, paint chips, plaster or hair? Yes No
9. Does this child have any trouble sleeping?..... Yes No
10. When was he/she last seen by a dentist (Date: _____)(If over six months check "No")..... Yes No
11. Was all the dental work suggested completed?..... Yes No
12. Was this child seen by a doctor since last clinic exam?..... Yes No
If yes, when? _____ What for? _____
13. Is child taking any medicines now (For example, aspirin, laxatives, etc)?..... Yes No
If yes, what medication? _____ What for? _____
14. Past history – Circle any of the following this child has ever had:
 - "Red" or "Hard" measles
 - German or 13-Day Measles
 - Mumps
 - Physical handicap
 - Convulsions, seizure, fits
 - Heart trouble
 - Allergies (Eczema, hives, drug or food intolerance, hay fever, wheezing or asthma)
 - Kidney or bladder infection
 - Diabetes
 - Pneumonia
 - Meningitis
 - Scarlet fever
 - High fever (above 104 for 3 days or more)
 - Birth injury or defect
 - Head injury
 - Chickenpox
 - Premature birth
 - Trouble breathing at birth
15. Recent history - Circle any the child had had recently:
 - Frequent urination
 - Small stream or dribbling
 - Burning or painful urination
 - Constant cold
 - Bowel problems
 - Dizziness, fainting spells
 - Tires easily
 - Swollen glands
 - Shortness of breath
 - Difficulty hearing
 - Bleeds easily
 - Joint pain
16. Other illnesses or diseases?..... Yes No
If yes, what? _____
17. Has this child been hospitalized? Yes No
If yes, for what? _____
18. Has this child had any serious accidents or ingestions?..... Yes No
If yes, list type, when, how treated? _____
19. Does this child have any physical restrictions?..... Yes No
If yes, what? _____
20. Has this child ever been seen by a medical specialist?..... Yes No
If yes, who? _____
21. Has this child ever had a sickle cell test? (If yes, when? _____)..... Yes No