Dunkerton Community School District- Health History Record

I. Identifying Information

Student Name _____ Birth Date _____ Age _____

Address _____

Father's Name _____Age ____ Occupation _____ Phone _____

Mother's Name _____ Age ____ Occupation _____ Phone_____

Other children/adults in the home: _____

_____

II. Prenatal History

Age of mother at time of pregnancy? _____ Did this child's mother have any illness/accidents/hospitalizations

during pregnancy? **Y / N** –if yes, please give more information: _____

_____

Did mother smoke during pregnancy? **Y / N** Did mother drink alcohol? **Y / N** Did mother take any illicit substances? **Y / N**

_____

III. Birth History

Place of birth (Hospital and City/State): _____

Did the mother carry the child to full term? **Y / N** – If no, how many weeks premature? _____

Type of delivery: ____ Vaginal ____ C-Section _____ Breech

Any complications during delivery? _____

_____

Birth Size _____ Pounds _____ Ounces _____ Length APGAR scores (if known) _____

Was oxygen administered after birth? **Y / N** –if yes, how long? _____

Did your child stay in the NICU? **Y / N** –if yes, how long? _____

Please describe your child as an infant. Were there any sleeping or eating difficulties? Were they active? Please describe any medical concerns during the first 12 months of life. _____

_____

IV. Growth and Development

At what age did your child begin crawling _____ Begin walking _____

Become completely toilet trained _____ Begin talking in 3-4 word sentences _____

Did your child receive any early intervention services? **Y / N** –if yes, what for _____

Have you observed your child (please circle): Banging head / Holding breath / Biting nails / Thumb sucking?

Does your child relate well with their siblings and other children? **Y / N** Explain: _____

Does your child have any difficulty sleeping through the night? **Y / N** –if yes, what is done to help get them to sleep?

_____

Do you have any concerns with your child's development? _____

_____

V. Disease/Diagnosis History

Please circle if your child has had any of the following:

Food Allergies	Anxiety	Concussion	Eczema
Environmental Allergies	Autism	Dental Concerns	Headaches
Drug/Medicine Allergies	Behavior Disorder	Depression	Hearing Impairment
Asthma/Wheezing	Celiac Disease	Diabetes	Heart Condition
ADD/ADHD	Chicken Pox	Ear infection/Tubes	Hemophilia
Epilepsy/Seizures	High fevers	Pneumonia	Kidney Disease
Orthopedic Impairment	Visual Impairment	Migraines	Other (Describe):

_____

_____

Has your child experienced any severe injuries? Fractures? Burns? _____

_____

Has your child had surgery? **Y / N** –if yes, for what and date: _____

_____

Does your child have a history of illness, hospitalizations, or accidents (for which they received medical care?)

_____

_____

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Does your child show any aggression? **Y / N** –if yes, please describe: _____

_____

Are they easily angered or destructive? **Y / N** –if yes, please describe: _____

_____

Who is your child's current medical provider(s) and/or specialists? _____

_____

What past and current medical diagnosis does your child have? _____

_____

Does your child take medication on a regular basis? **Y / N** –if yes, please list medication, dosage, & reason for medication

_____

_____

_____

VI. **<u>Family History</u>** (include the child's biological parents, siblings, and grandparents):

Vision	Color Blindness	Mental Impairment	Diabetes
Cataracts	Speech Defects	High Blood Pressure	Emotional Problems/Anxiety
Glaucoma	Hearing Defects	Epilepsy/Seizures	Heart Condition
Glasses	Orthopedic Impairments	Kidney Disease	Cancer- Type: _____

Additional information/Comments:

_____

_____

_____

_____

Form filled out by: _____

Relationship to Child: _____ Date: _____

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To be filled out by Health Office:

Health History received by:	Date:
Information updated in Infinite Campus:	Date: