

## 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	Child & Teen Check-ups	Child care center
Early Childhood Special Education	School-based pre-K	Family/neighbor care
Follow Along program	Private preschool	Library
Parenting Education	Head Start	WIC
Parks and Recreation programs	Foster Care	Food shelf

## HEALTH

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

Allergies:    food    medicine    animals/insect    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 three 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: \_\_\_\_\_

**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.

Gets 60 minutes or more of exercise each day

Has difficulty falling/staying asleep

Is NOT able to/does NOT get 60 minutes of exercise

Takes a nap: from \_\_\_\_ to \_\_\_\_

\_\_\_\_ 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 SAFETY

### Current housing situation:

Renting or homeowner                      Doubled up with friends or family                      Hotel or motel

Emergency shelter/transitional housing                      Unsheltered (cars,parks,and campgrounds, temporary)

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(use safety lock)

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                      smoke detector                      carbon monoxide detector

## LEARNING

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

If not, please explain: \_\_\_\_\_

My child needs help with:                      toileting                      activity/mobility                      dressing                      nutrition/eating (Help to eat Oranges? Milk?)

Other: \_\_\_\_\_

### Please check any of the following:

Says numbers 1 to 10

understands other people

Has trouble speaking or hard to understand

Able to follow directions

Has trouble being understood by others

Plays in a variety of ways

Seems clumsy when using hands

Walks or runs poorly (falls)