Adapted from
Minnesota Visiting Nurse Agency
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413

Health History

(To be completed by parent/guardian before admission)

Child's Name: _____ Birth Date: _____

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 a 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 (Pica)… ❑ 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** he 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
- 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 (_____ weeks early)
- Trouble breathing at birth
- Allergies (Eczema, hives, drug or food intolerance hay fever, wheezing or asthma)

15. **Recent history** – Circle any the child has 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

(CONTINUED ON REVERSE SIDE)

Section B: Growth And Development History

1. Does this child get along well with:

Parent/Caregiver 1	❑ Yes	❑ No	
Parent/Caregiver 2	❑ Yes	❑ No	❑ Not Applicable
Additional Parents/Caregivers	❑ Yes	❑ No	❑ Not Applicable
Brothers	❑ Yes	❑ No	❑ Not Applicable
Sisters	❑ Yes	❑ No	❑ Not Applicable
Other children	❑ Yes	❑ No	❑ Not Applicable

Comments: _____
_____
_____
_____

2. Are you concerned about your child in any of the following areas?

a. Bedwetting	❑ Yes	❑ No
b. Wetting during the day	❑ Yes	❑ No
c. Difficulty going to bed or staying in bed	❑ Yes	❑ No
d. Bad dreams, wakefulness, disturbed sleep	❑ Yes	❑ No
e. Biting nails, nervous habits	❑ Yes	❑ No
f. Thumb sucking	❑ Yes	❑ No
g. Stammering or stuttering	❑ Yes	❑ No
h. Irritability, easily upset, feelings hurt easily	❑ Yes	❑ No
i. Restlessness, over activity	❑ Yes	❑ No
j. Daydreaming, mind not on what's he's doing	❑ Yes	❑ No
k. Overly cautious, fearful, shy	❑ Yes	❑ No
l. Wanting too much attention, comfort, or support; clinging	❑ Yes	❑ No
m. Breath holding	❑ Yes	❑ No
n. Contrary, stubborn, uncooperative, disobedient	❑ Yes	❑ No
o. Selfishness, inability to share	❑ Yes	❑ No
p. Jealousy	❑ Yes	❑ No
q. Anger, temper tantrums	❑ Yes	❑ No
r. Destroying things on purpose	❑ Yes	❑ No
s. Clumsiness, awkwardness	❑ Yes	❑ No
t. Too much concern about sex for age	❑ Yes	❑ No

Comments: _____
_____
_____
_____
_____

3. What experience has this child had with groups (day care, preschool, Head Start, church or temple school)?
_____

4. Is there anything additional that you would like to tell us about your child? _____
_____
_____
_____
_____
_____
_____
_____
_____

Parent/Caregiver Signature:	Date Signed: