Reach Dane
Head Start

Health and Developmental History

First Year (page 1 of 2)

Label Here
Child's Name _____
Program _____
PY _____

Child's Name (First, Last) Birth date Date history completed

Parent/Guardian's Name (First, Last) Parent/Guardian's Name (First, Last)

Doctor's Name Clinic Name Date of Last Physical Exam

Dentist's Name Clinic Name Date of Last Visit (if haven't been, date scheduled)

Do you need assistance with transportation to a medical and or a dental appointment?

Is this child covered by:

o Medical Assistance ID No. _____
Copy 10-digit MA# from bottom of Forward Card

HMO:
o Quartz o Dean o Physician's Plus o GHC
o Straight o Benchmark o Unsure
o Other (name): _____

o Applying for Medical Assistance

o Applying for Private Insurance

o Private Medical Company: _____
Account #: _____
HMO, if any?
o Quartz o Dean o Physician's Plus o GHC
o Other _____

o Private Dental Company: _____
Account #: _____
HMO, if any?
o Quartz o Dean o Physician's Plus o GHC
o Other _____

PREGNANCY/BIRTH HISTORY	YES	NO	EXPLAIN "YES" ANSWERS
1. Where was this child born? (city or country)			
2. Did mother have any health problems during this pregnancy or delivery? Did she take drugs or alcohol then?			
3. Was child born more than three weeks early or late?			
4. What was child's birth weight?			Lbs. Oz.
5. Was anything wrong with child at birth or in the nursery?			
6. Did the child come home from hospital with the mother? If no, how long did he/she stay?			
HOSPITALIZATION: Has this child:			
1. Ever been hospitalized or operated on?			
2. Ever had a serious accident? (broken bones, car accident, head injury, falls, burns, poisoning)			
3. Ever had a serious illness? Describe:			
HEALTH CONCERNS			
1. Does this child have frequent: sore throats, coughs, bladder/urinary infections, eating/stomach problems, vomiting, diarrhea or constipation (circle)			
2. Does your child have any vision/eye problems? (Squints, weak muscles, etc.)			
3. Is child wearing (or supposed to wear) glasses? If yes, give doctor and exam date. ***Staff: remember to do release form for eye doctor.***			Eye Doctor: Date of last exam:

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First Year (page 2 of 2)

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	YES	NO	EXPLAIN "YES" ANSWERS
4. Does child have any ear/hearing problems? (Frequent infections, pain, etc.) ***Staff: if child is under care for ears, do a release for assigned MD***			
5. Does child currently have, or ever had, "tubes" in the ears?			
6. Has child ever had a convulsion or seizure? When was the last seizure? Is child on medication now for seizures?			Date: Name of medication:
7. Is child taking medication now for any reason? Why?			Name of medication:
8. Has child had: *(circle)* eczema, scarlet fever, asthma, bleeding problems, diabetes, heart murmur, heart disease, liver disease, respiratory/lung disease, sickle cell disease, lead poisoning, intestinal parasites, failure-to-thrive, speech/language problems			
9. Do family/friends smoke in your home or car while children are present?			
10. Has child had chicken pox disease?			Year: If no – Varicella vaccine required
11. Does child have any allergies? to food, to medication, to animals, to plants, trees, grass, insects, bee stings? (circle all that apply)			
12. If yes in 11 above, does this child have "Epi-pen" for allergic reactions? Has "Epi-pen" or "Medic-Alert" bracelet ever been suggested by a doctor?			
13. Does this child have any other serious disease or conditions?			
14. Do you feel your child's overall growth and development is about the same as other children the same age? If no, please describe:			
15. Does this child: wet the bed, suck thumb, twist hair, bite fingernails, have temper tantrums, hurt self intentionally (circle)			
16. Do you have any particular concerns about your child's emotional development? (seems excessively shy, aggressive, withdrawn)			
17. Has a medical provider or therapist ever diagnosed this child with a social/emotional condition? ***Staff: do release for diagnosing provider***			Who: Diagnosis:
18. Has child ever seen or experienced abuse, violence, or trauma? Please describe:			
19. Does your child complain of being tired, appear sluggish, or seem to be lacking in energy?			
20. Does your child complain often of aches/pains; stomach or head aches, etc?			
21. Is your child clumsy, awkward, run poorly, stumble or fall, etc?			
22. Is your child clumsy in doing things with his/her hands?			
23. Does your child receive services from a therapist or school district person? ***Staff: remember to do release form***			Who: For what:

DENTAL HISTORY

1. Has child ever been to the dentist: Dentist:	Yes	No	If no, state reason why: Most recent/scheduled Date:	
2. Does child: complain of toothaches, have cavities, holes, black spots, have missing teeth due to injury? (circle all that apply)				
3. Does your child have a toothbrush?	Yes	No	How often used?	
4. Do you use private well water? If using well water, has the well been tested for:	Yes	No	Take fluoride pills? Bacteria _____	Yes No Nitrates _____ Fluorides _____