

PINE HILL SCHOOLS MEDICAL HISTORY FORM

Child's Name _____ Child's Birth Date _____

PRENATAL HISTORY:

Was the mother in good health during pregnancy with this child? Yes ___ No ___

If no, state problems _____

Did mother take any medications during this pregnancy? Yes ___ No ___

If yes, list medications taken _____

Were you or the doctor worried about this pregnancy for any reason? Yes ___ No ___

If yes, state reason for worry _____

Length of pregnancy _____ Length of labor _____

Anesthesia used? Yes ___ No ___ Instruments used? Yes ___ No ___

Delivery was : Normal ___ Breech ___ Caesarean ___

Birth weight of child _____ Length of child _____

POSTNATAL HISTORY:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Oxygen therapy for baby	___	___	Difficult breathing	___	___
Breast fed	___	___	Bottle fed	___	___
Difficulty swallowing	___	___	Jaundice	___	___
Colic	___	___	Feeding schedule	___	___
Did your baby go home with you when you left the hospital?	___	___			
If no, explain	_____				

FAMILY MEDICAL HISTORY:

Has anyone in the family ever had:	<u>Yes</u>	<u>No</u>	<u>Indicate relationship</u>
Diabetes	___	___	_____
Tuberculosis	___	___	_____
Heart disease	___	___	_____
High blood pressure	___	___	_____
Stroke	___	___	_____
Kidney disease	___	___	_____
Cancer	___	___	_____
Mental illness	___	___	_____
Asthma	___	___	_____
Genetic diseases	___	___	_____

Has child had:

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
Allergies	___	___	_____
Chronic illness	___	___	_____
Asthma/wheezing	___	___	_____
Chickenpox	___	___	_____
Pneumonia/Bronchitis	___	___	_____
Frequent sore throat	___	___	_____
Frequent ear infections	___	___	_____

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Has child had:

	<u>Yes</u>	<u>No</u>	<u>Explain</u>
Frequent vomiting/diarrhea	___	___	_____
Convulsions/seizures	___	___	_____
Eczema/hives	___	___	_____
Reaction to insect bites	___	___	_____
Bleeding problems	___	___	_____
Thumb/finger sucking	___	___	_____
Nightmares/sleep disturbance	___	___	_____
Temper tantrums	___	___	_____
Bed wetting/toilet problems	___	___	_____
Problems with vision	___	___	_____
Problems with hearing	___	___	_____
Problems with speech	___	___	_____
Any SEVERE injury	___	___	_____
Any operations	___	___	_____
Any long-time chronic illness	___	___	_____
Any special medication	___	___	_____
Any physical restrictions	___	___	_____
Physical abnormality/disability	___	___	_____
Diabetes	___	___	_____
Heart trouble	___	___	_____

NUTRITION:

Appetite: Good ___ Picky ___ Other _____
Food quirks: _____
Unusual weight gain or loss, explain _____

SUMMARY

Is there anything in regard to your child's health or behavior that you would like to comment upon ?

May we share this information with your child's teacher? Yes ___ No ___

PARENT SIGNATURE

DATE