Child's Health History Checklist
Judson Weekday

Child's Name	Birthdate	Parent's Name

Pregnancy and Birth

Yes No Were there any problems with pregnancy or your child's birth?
Yes No Was his/her birth weight under 5½ pounds?
Yes No Did the baby have any problems in the hospital?

Medical Problems

Yes No Has your child ever been in the hospital overnight?
Yes No Is your child taking any medicine? If so, what? _____
Yes No Any allergies or reactions to medicine, immunizations, or insects?
Yes No Has your child had asthma or wheezing?
Yes No Does your child have speech or hearing problems?
Yes No Has your child had more than two ear infections in a year?
Yes No Has your child had tonsillitis?
Yes No Does your child have trouble with his/her eyes or seeing?
Yes No Has your child had a bladder or kidney infection?
Yes No Does he/she have burning when urinating?
Yes No Does he/she have seizures or shaking spells?
Yes No Have you ever been told your child has a heart murmur?
Yes No Is your child able to play as hard as other children?
Yes No Has your child ever had a bumpy, swollen reaction to the TB skin test?
Yes No Has your child ever been with anyone having TB?
Yes No Is your child a hemophiliac (free bleeder)?
Yes No Is your child on a heart monitor?
Yes No Does your child have tubes in his/her ears?

General Development

Yes No Does your child play well with other children?
Yes No Is he/she usually happy?
Yes No Does your child have any behavior habits (biting nails, sucking fingers, tantrums, biting, stammering, etc.)? _____
Yes No Does your child have any fears? What are they? _____
Yes No Is it difficult for your child to be separated from either parent?
Yes No Does your child have any special problems not indicated above?
If yes, what? _____
When did your child last see a doctor? month/year _____/_____