NOCAC EARLY HEAD START – 0-12 Months
HEALTH/DENTAL/DIETARY HISTORY FORM

Child's Name _____ M or F Date of Birth _____

HEALTH HISTORY

Date of last well child exam _____ Name of Doctor/Facility/Medical Home_____

Birth weight _____ Received Prenatal Care Yes or No

Mother's health during pregnancy _____

Tobacco Use during Pregnancy Yes or No Alcohol Use during Pregnancy Yes or No

Check any of the following which have been a problem for any member of your family, including grandparents:

____ mental retardation ____ skin allergies ____ heart disease ____ birth defects ____ asthma

____ epilepsy ____ cancer ____ diabetes ____ convulsions ____ None apply

Other _____

Did your child have problems at birth and or born early? (i.e. jaundice, oxygen needed, didn't cry, etc.)

_____

Please mark the following conditions that apply to your child with an **"E", "P" or "L"**

(indicating **E**xisting, **P**ast or **Life Threatening** condition)

____ Diabetes	____ Bowel/bladder accidents	____ Heart trouble
____ Asthma	____ Bone/orthopedic	____ Neurological problems
____ Medications	____ Constipation/diarrhea/food intolerance	____ Allergic Condition[3]
____ Foods	____ Seizures with/without fever	____ Serious accident/injuries
____Insects	____ Eczema/skin condition	____ Surgery/hospitalization
____Latex	____ Eating/swallowing difficulties	____ Urinary tract infections
____ Pollens/dust	____ Exposure to TB/respiratory disease	____ Vision: wears glasses/patch
____ Cancer	____ Anemia/sickle cell/blood disease	____ Hearing/ear problems

____ Other _____

Please explain the LIFE THREATENING[1] or any Existing conditions[3]: _____

_____

Do you have any concerns about your child's health? ☐ Yes ☐ No If yes, what? _____

Does your child take any medicine (vitamins, prescription or over the counter) on a regular basis? ☐ Yes ☐ No

If yes, what? _____

Will it need to be given to your child at school? ☐ Yes[2 or 3] ☐ No

Does your child have special needs or need help to participate in classroom activities (i.e. help with toileting, etc.)?

☐ Yes[3] ☐ No If yes, what? _____

Has your child ever been tested with a finger stick (poke) for lead or hemoglobin? ☐ Yes ☐ No

When _____ Where _____

FOR STAFF USE: **REFERRALS: a - Health Manager b - Dietitian c - WIC/Health Insurance-FA**

1-Complete ROI 2- Complete Med Administration Plan 3- Complete Medical Care Plan Rev 8/19mb

DENTAL HISTORY

Date of last dental exam _____ Dentist Name _____ ☐ My child does **NOT** have a dentist.

Has your child ever had any cavities? ☐ Yes ☐ No If yes, have they been fixed? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Do you help brush his/her gums/teeth? ☐ Always ☐ Sometimes ☐ Never

Does your child drink from a bottle or spill-proof cup at bedtime/naptime? ☐ Yes ☐ No If yes, content _____

Do you have concerns about your child's teeth(i.e.pain/bleeding/spots/cavities on teeth, broken/cracked teeth, foul odor from mouth)? - Yes or No * If yes, explain _____

Do you have family dental concerns? ☐ Yes ☐ No If yes, explain _____

Does your house receive water from the city water supply, well, pond or cistern? Please circle which applies.

Does your family drink tap water? Yes ____ No ____ Does your family drink bottle water? Yes ____ No ____

DIET/NUTRITION HISTORY

How do you feed your baby? ___ Breastfeed ____ Breast and Bottle ____ Bottle

If you are breastfeeding, how many times in 24 hours do you breast feed?_____

Do you have any concerns about breastfeeding?_____

How many ounces does your baby drink at each feeding?_____

If you are bottle feeding, how many times does your baby get a bottle in 24 hours?_____

How many ounces does your baby drink at each feeding?_____

What do you use? ____ Concentrated Formula ____ Powdered Formula ____ Ready to Feed ____ Fresh Milk

How do you prepare your formula?_____ What Brand do you use?_____

Do you put your baby to bed with a bottle? ____Yes ____No

What else do you put in your baby's bottle? ____ Water ____Water w/Sugar ____ Honey ____ Karo Syrup ____ Jello Water ____ Rice Water ____ 100% juice ____ Cereal ____ Hi-C ____ Lemonade ____ Punch ____ Kool Aid ____ Soda ____ Tea ____ Coffee ____ Chocolate Milk ____ Sport Drink (Gatorade)

Which do you feed your baby? ____ Homemade Baby Food ____ Baby Food in Jars ____ Bottle Only

Who else feeds your baby? _____

My baby has: Allergies _____ ____ Diarrhea ____ Constipation ____ None of these

Do you have any questions about the way your baby is eating? ____Yes ____ No

If Yes, please explain:_____

Women Infants & Children

WIC is a nutrition education program which provides nutritious supplemental foods for postpartum women, breastfeeding mothers, infants and children up to age 5. Some examples of possible supplemental foods provided are baby formula, milk, eggs, cheese, and cereal.

Are you interested in receiving WIC services?

____ Yes, I already receive WIC. ____ No, but I would like to receive WIC.[c]

____ No, I am not interested in WIC because _____

Do you currently have health insurance? Yes ____ No ____[c]

The information provided on this form is accurate and true to the best of my knowledge.

_____ _____

Parent/legal Guardian Signature Date

_____ _____

Head Start Staff Signature Date

Center Site _____ Classroom _____

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