NOCAC EARLY HEAD START – 13 - 36 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 _____

Problems for child at birth and or born early? (i.e. jaundice, oxygen needed, didn't cry) _____

_____

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 or No *If yes, what? _____

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

*If yes, what? _____

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

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

– Yes[3] op No *If yes, what? _____

Has your child ever been tested with a finger stick (poke) for lead or hemoglobin? – Yes or 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 8/19cw

DENTAL HISTORY

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

Has your child ever had any cavities? – Yes op No *If yes, have they been fixed? - Yes op No

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

Do you help brush his/her gums/teeth? - *Always* op *Sometimes* or *Never* (Please, circle one)

Does your child drink from a bottle or spill-proof cup at bedtime/naptime? - Yes op 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 op 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 or No Does your family drink bottled water? - Yes or No

DIET/NUTRITION HISTORY

Does your family restrict any foods for religious, cultural, ethical or personal reasons?

Yes[b] or No *If yes, what foods and why? _____

Does your child have any chewing or swallowing problems?

Yes[a] or No *If yes, explain _____

Do you have any concerns about what your child eats or weighs?

Yes[b] or No *If yes, explain _____

Does your child refuse to use silverware, throw food, or do other things that upset your meal time? - Yes op No

Explain _____

Does your child have a problem using: *fork spoon knife cup* (Circle all that apply)

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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