Health History
Early Childhood Screening (ECS)

Child's Name__________ Boy ☐ Girl ☐ Birthdate__________

Home Address__________ (Address / City / State / Zip)

Parent's Name__________ Phone__________ (Daytime / Evening)

Address (if different)__________

Other Parent's Name__________ Phone__________ (Daytime / Evening)

Family Information: Please list other family members (adults and children) living in your home.

Name	Relationship to Child	Birthdate	M or F
1.			
2.			
3.			
4.			
5.			
6.			

HEALTH CARE	Physician/Health Care Provider__________ Date of last physical______ Dentist__________ Date of last dental______ Does your child have health insurance? ☐No ☐Private insurance ☐MA or MN Care ☐Other______
EYES/ VISION	☐ Has problems with his/her eyes (squinting, crusty lids, mattering) ☐ Eyes turn in or out ☐ Tilts head to see ~~☐ Eyes cross or wander separately ☐ Holds items close to eyes ☐ Wears glasses or contacts~~ ☐I have concerns about my child's vision. Explain__________ Last vision check______
EARS/ HEARING	☐ Has had ear problems 2 or 3 times within a year ☐ Speaks loudly ☐ Says "what?" often ☐ Has had earaches or discharge from the ear within the past six months ☐ Seems to have trouble hearing ☐ Has had ventilation (PE) tubes put in his/her ears ☐ Other__________
Has your child had:	☐ Seizures ☐ Strep Throat ☐ Heart Disease ☐ Scarlet Fever ☐ Medication Allergy______ ☐ Asthma ☐ Meningitis ☐ Red Measles ☐ Eczema, Hives, Rashes ☐ Food Allergy______ ☐ Mumps ☐ Pneumonia ☐ German Measles ☐ Rheumatic Fever ☐ Severe reaction to insect bite ☐ Diabetes ☐ Chicken Pox ☐ Whooping Cough ☐ Allergies ☐ Reaction to an immunization
☆	Chronic health problem__________ Serious accident (falls, head injury, poison, broken bones)__________ Hospitalizations__________ Surgery__________ Seen by a specialist__________ List medications that your child takes regularly__________

Health History *(Check ✓ all that apply to your child):*

FAMILY HISTORY

1. ☐ Child is adopted. At what age? _______ ☐ I have no health information on my adopted child.
2. Have any of your child's blood relatives (parents, grandparents, aunts, uncles, brothers, sisters) ever had any of the following?

☐ Allergy or Hayfever	☐ Diabetes	☐ Eye abnormalities	☐ Liver disease
☐ Asthma	☐ Epilepsy (seizures)	☐ High Blood pressure	☐ Cancer
☐ Cleft lip or palate	☐ Reading problems	☐ Growth problems	☐ Heart problems
☐ Deafness	☐ Mental Illness	☐ Mental Retardation	☐ Rheumatic fever
☐ Tuberculosis	☐ Convulsion	☐ Drug or alcohol problem	

Explain____

Inherited or family diseases:

☐ Thalassemia	☐ Cystic Fibrosis	☐ Sickle Cell Anemia
☐ Blood disorders	☐ Muscular Dystrophy	☐ Other Family Diseases

3. Are there several family members who have had the same or similar physical/mental problems?___________

____

PREGNANCY & BIRTH

1. ☐ Mother had health problems during the pregnancy with this child_______________________
   - ☐ Visited the physician fewer that 2 times Actual birth weight:__________lbs. __________oz.
   - ☐ There were difficulties during labor and/or delivery ☐ My child had difficulties at birth
   - ☐ Child was more that three weeks early or late ☐ Child had problems in first week
   - ☐ Mom pregnant now
2. Mother used the following during pregnancy with this child: If yes, indicate which trimester(s).

	0-3 months	4-6 months	7-9 months
☐ Aspirin	☐	☐	☐
☐ Alcohol	☐	☐	☐
☐ Laxatives	☐	☐	☐
☐ Cigarettes	☐	☐	☐
☐ Street Drugs	☐	☐	☐
☐ Other, describe:____________________	☐	☐	☐

GASTRO-INTESTINAL

☐ Vomits frequently ☐ Has diarrhea frequently ☐ Foods disagree with ☐ Has bloody stools
☐ Has frequent stomach aches ☐ Has trouble with constipation ☐ Has anal itching

CARDIO-VASCULAR

☐ Hands and fingers turn blue ☐ Seems to tire easily ☐ Has heart trouble ☐ I have been told my child has a heart murmur

NEURO-MUSCULAR

☐ Loses his/her balance in unusual ways ☐ Has some unexplained movements or jerks ☐ Has staring spells
☐ Has had convulsions or seizures ☐ Has a weakness in his/her body
☐ Is clumsy and awkward ☐ Seems to fall down more than other children

URINARY

☐ Is not toilet trained ☐ Has trouble wetting during the day
☐ Has trouble with bed wetting ☐ Has had a kidney or bladder infection

SKELETAL

☐ Complains of pains in arms, legs, back ☐ Limps, toes in or out ☐ Has had a broken bone, case, brace, or corrective shoes

DENTAL

1. Source of water at home: ☐ city ☐ private well ☐ rural water system ☐ other ☐ don't know
2. Receives fluoride from any of the following sources:
   ☐ vitamins ☐ toothpaste ☐ tablets/drops ☐ mouth rinses ☐ dental office treatment

☐ Has teeth brushed daily or brushes own teeth daily ☐ Has had dental sealants placed on one or more teeth
☐ Has had a toothache ☐ Has had teeth chipped or damaged in any way
☐ Has trouble with teeth, gums, or mouth. Explain:_______________________

LEAD POISONING RISK QUESTIONS

☐ Does your child lives in or regularly visits a house that was built before 1950 (daycare, home, relative)?
☐ Does your child lives in or regularly visits a house built before 1978 with ongoing remodeling?
☐ Does your child have a sibling or playmate who had or did have lead poisoning?
☐ Child receives services such as: ☐ MA ☐ WIC ☐ Head Start
Has your child ever had a blood lead test? ☐ Yes ☐ No ☐ Unknown

Please read the following list and indicate those which your child is having trouble with:

Self Help:

- ☐ toileting
- ☐ dressing
- ☐ doing fasteners, buttons, or zippers
- ☐ eating
- ☐ following routines
- ☐ sleeping

Motor:

- ☐ walking without tripping
- ☐ using pencils, scissors, crayons
- ☐ catching a ball
- ☐ playing safely at a park
- ☐ cutting with scissors

Communication:

- ☐ being understood when talking
- ☐ telling wants, ideas, or activities
- ~~☐ talking in sentences~~
- ☐ following directions
- ☐ answering questions

Socializing:

- ☐ making friends
- ☐ keeping friends
- ☐ separating from caregiver
- ☐ working in a group
- ☐ staying with one activity at a time
- ☐ showing emotions appropriately

Learning:

- ☐ knowing expected information
- ☐ tries different ways to solve problems

Parent Concerns Not Listed:

____

____

____

____

____

Do you consider your child at risk for learning?

- ☐ No
- ☐ Yes - Explain ______________________________

____

____

____

Does your child display any of these?

Behavior

- ☐ breaks things (destructive)
- ☐ has tantrums
- ☐ tests limits
- ☐ is uncooperative
- ☐ resists rules
- ☐ clings to an adult
- ☐ is easily distracted
- ☐ worries a lot
- ☐ is fearful
- ☐ persists when asked to stop
- ☐ darts around
- ☐ has trouble staying with task
- ☐ does things the hard way

Development:

- ☐ does things later than you would expect
- ☐ acts younger than own age
- ☐ only plays with younger kids

At what age did your child:

Sit without support ____________________

Stand without support ____________________

Walk ____________________

Talk in sentences ____________________

Dresses without help ____________________

Become toilet trained ____________________

Preschool Experience:

- ☐ ECFE
- ☐ ECSE
- ☐ Daycare (family/structured)
- ☐ Structural Preschool
- ☐ Sunday School
- ☐ Head Start
- ☐ Other ______________________________
- ☐ None

Family Factors

1. How would you describe your child?

2. What is a typical day like (bed time, naps, eating, etc.)?

3. What are your child/family's favorite activities (toys books, TV, pets, etc.)?

4. What do you do when your child doesn't obey/cooperate; type of discipline that works best?

5. Are there any factors which make things hard for your family at this time (financial, marital, new home)?

6. Comments (any thing that is important for us to know that wasn't covered?):

Informant:________________________ Interviewer:________________________