

Chase Lake Elementary Preschool
Health History

Child's Name: _____ Sex: M F Birth Date: _____

Family History:

Mother's Age: _____ Health: _____ Father's Age: _____ Health: _____
Brother's Ages: _____ Health: _____ Sister's Ages: _____ Health: _____

Check if any family members have had, and indicate which family member is/was affected:

_____ Allergies (what kind?) _____	_____ Epilepsy (seizures) _____
_____ Arthritis _____	_____ Heart Disease _____
_____ Bleeding Disorders _____	_____ High Blood Pressure _____
_____ Cancer _____	_____ Tuberculosis _____
_____ Diabetes _____	_____ Ulcers _____
_____ Other _____	

The Child's History: Position in family (1st child, 2nd, etc) _____

Birth weight: _____ lb _____ oz Length of pregnancy _____ months Normal Delivery?: _____

Mother healthy during pregnancy?: _____ Baby healthy after delivery?: _____

At what age did your child?

Sit alone without support _____	Talk (understandable words) _____
Stand alone _____	Toilet trained, day _____
Walk _____	Toilet trained, night _____

Please check the illnesses or problems your child has or has had:

_____ Allergy (to what?) _____	_____ Medication reaction _____
_____ Anemia _____	_____ Mumps _____
_____ Asthma _____	_____ Pneumonia _____
_____ Chicken Pox _____	_____ Rubella (3-day measles) _____
_____ Ear Problems _____	_____ Seizures _____
_____ Eczema _____	_____ Strep Throat _____
_____ Measles _____	_____ Tonsillitis _____
_____ Surgery or hospitalization _____	
_____ Other _____	

Does your child take any medicine routinely or for a recurrent problem? _____

Do you have any concerns about your child's:

Behavior _____	Elimination _____
Coordination _____	Hearing or vision _____
Development _____	Sleeping _____
Eating _____	Other concerns _____

Health Care

Last physical exam _____ Clinic or doctor's name _____
Last dental exam _____ Any ongoing problems _____
Other doctors or clinics (speech, eye, etc.) _____

Date _____

Parent's Signature _____