PART I

PREGNANCY HISTORY OF CHILD

Child's Name: _____ Date of Birth: _____

During this pregnancy did you have?

	YES	NO	DESCRIBE
ANEMIA			
ELEVATED BLOOD PRESSURE			
TOXEMIA			
SWOLLEN ANKLES			
KIDNEY DISEASE			
HEART DISEASE			
BLEEDING			
MEASLES			
GERMAN MEASLES			
VOMITING			
INJURY			
THREATENED MISCARIAGE			
MEDICINE DURING PREGNANCY			
OTHER ILLNESS			
RH FACTOR			

BIRTH HISTORY

BABY'S WEIGHT at BIRTH: _____lbs. _____oz **APGAR SCORE (if known) _____**
Was the baby premature? (Yes) ____ (No) _____
Did the baby cry quickly? (Yes) _____ (No)_____
Was the baby 's coloring normal? (Yes) ____ (No)____
Did the baby have a breathing problem? (Yes) ____ (No) ____ **Cord around neck? (Yes) ____ (No) ____**
Was oxygen used for the baby? (Yes) ____ (No)____
Was labor induced? (Yes) ____ (No) ____ WHY? _____
Was delivery unusual in any way? (How?) _____
Did you have a Caesarean Section? (Yes) ____ (No)____

PART II

DEVELOPMENTAL HISTORY

At what age did your baby:

	AGE IN MONTHS
1. Sit up?	
2. Say "Ma Ma" or "Da Da"?	
3. Stand?	
4. Walk?	
5. Use words?	
6. Use short sentences?	
7. Have bladder control?	
8. Have bowel control?	
9. Run?	
10. Ride a tricycle?	

ANSWER YES OR NO BELOW

11. Can your child copy a circle? _____ 12. Can your child stand on one foot? _____
13. Can your child skip? _____ 14. Can your child copy a square? _____
15. Does your child seem to have any problems that you haven't mentioned or do you have any problems with your child? Please tell us about them

_____
_____

PART III

MEDICAL HISTORY OF CHILD

Child's Name: _____ Date of Birth: _____

Has your child had or have:

ALLERGIES:	YES	NO	Treatment or Explanation
Bee Sting			
Food			
Other			

ASTHMA:	YES	NO	Treatment

DIABETES:	YES	NO	Treatment

Hematology/Oncology Conditions:	YES	NO	Treatment or Explanation
Anemia			
Sickle Cell			
Lead Poisoning			
Other			

Neurologic Conditions:	YES	NO	Age	Treatment or Explanation
Convulsions				
Lyme Disease				
Migraines				
Other				

Vision or Hearing Conditions	Explanation

Psychiatric Conditions:	YES	NO	Age	Explanation
Depression				
Eating Disorder				
Other				

	Age	Explanation
Hospitalizations		
Operations		
Other injuries/conditions		
Other illnesses		

Would you like to mention anything else about your child's health or discuss with the school nurse?