



# Mid-America Head Start

## Medical/Social/Developmental History Form

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Head Start Site \_\_\_\_\_

Primary Care Physician/Medical Home\* \_\_\_\_\_ None

Address \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Dental Home\* \_\_\_\_\_ None

Address \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Number \_\_\_\_\_ Medicaid Private Insurance

Hospitalizations and Illnesses	No	Yes	Currently Receiving Treatment	Comments
Did mother have an abnormal pregnancy? If "yes", explain in "Comment" section. Birth weight _____				
Has your child ever been hospitalized or operated on? If "yes", explain in "Comment" section.				
Has your child ever had a serious illness or accident? If "yes", explain in "Comment" section.				

Medical and Dental History	No	Yes	Currently Receiving Treatment	Comments
Does your child have frequent: • Urinary infections or trouble urinating, or • Stomach pain, vomiting or diarrhea? If "yes", explain in "Comment" section.				
Does your child have or receive treatment for vision problems (squints, cross-eyed, holds books closely)?*				Name of Eye Doctor _____ Date of last visit _____
Does your child wear glasses?				
Does your child have or receive treatment for ears/hearing (pain in ear, frequent earaches, infections, drainage, hearing loss)?*				Name of Ear, Nose & Throat Specialist _____ Date of last visit _____
Does your child have ear tubes?				
Has your child ever had a convulsion or seizure? If "yes", explain in "Comment" section.				When did it last happen? _____ What medication was given? _____ Physician who treated child (if other than Primary Care Physician) _____
Is your child taking any medication?				Type of medication _____ Reason for medication _____
Is a physician or dentist currently treating your child for any condition? Please put date of your child's last physical and dental exam in the comments section. ----- Does your child receive preventative dental care?*				Name of physician (if other than primary care physician) _____ Date of last physical _____ Name of dentist (if other than primary care dentist) _____ Date of last dental exam _____

\* PIR question – must be answered by parent/guardian

Medical and Dental History	No	Yes	Currently Receiving Treatment	Comments
Has your child had chicken pox? If yes, please list month/year.				<i>Physician verification required.</i>
Does your child have or receive treatment for any of these conditions? <i>Check all that apply</i> <input type="checkbox"/> Anemia* <input type="checkbox"/> Bleeding tendencies <input type="checkbox"/> Diabetes* <input type="checkbox"/> Heart/blood disease <input type="checkbox"/> High lead level* <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Overweight* <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other _____				Condition _____ Name of Physician _____ Date of last visit _____
Does your child have or receive treatment for asthma?*				
Do you have an asthma action plan?				Name of Physician _____ Date of last visit _____ Medication given _____
Are there specific things that trigger your child's asthma?				
Are there any foods your child should not eat: <input type="checkbox"/> Medical <input type="checkbox"/> Religious <input type="checkbox"/> Personal If yes, explain in "Comment" section				<i>All special diet requests should include acceptable substitutions. Medical or personal reasons require special diet form signed by physician.</i>
Does your child suffer from allergies (rash, itching, difficulty breathing, sneezing) <input type="checkbox"/> When eating particular foods? <input type="checkbox"/> When taking specific medications? <input type="checkbox"/> When near animals, dust, pollen, insects? If yes, explain in "Comment" section				What foods _____ What medicines _____ What other allergens _____ What are the allergic reactions _____ _____ Doctor/emergency room visit required? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b><i>Has your child ever:</i></b> <input type="checkbox"/> complained of a toothache <input type="checkbox"/> had teeth missing naturally <input type="checkbox"/> had teeth missing from a mouth injury <input type="checkbox"/> received a fluoride treatment <input type="checkbox"/> had bleeding or inflamed gums <input type="checkbox"/> had a cavity <input type="checkbox"/> had a mouth injury <b><i>Does your child:</i></b> <input type="checkbox"/> eat sugary snacks <input type="checkbox"/> suck thumb or fingers <input type="checkbox"/> brush his/her own teeth <input type="checkbox"/> have a mouth swab after eating (infants)				
Does your child have a diagnosed disability? Does your child have an IEP or IFSP?				Name of diagnosing agency <input type="checkbox"/> First Steps provider _____ <input type="checkbox"/> Local school district _____ <input type="checkbox"/> Other _____
Are there any conditions that have not been discussed that your child has which could affect the child's every day activities? If yes, explain in "Comment" section.				

\* PIR question – must be answered by parent/guardian

## Physical, Psychological and Social Development

Can you tell us one or two things that your child does well?

Does your child nap Yes No When \_\_\_\_\_ For how long \_\_\_\_\_

Does your child sleep less than 8 hours at night? Yes No If yes, explain

How does your child let you know he/she has to go to the bathroom? \_\_\_\_\_  
Does your child still need help going to the bathroom? Yes No  
If yes, please explain:

How does your child respond to adults that he/she doesn't know?

How does your child respond to children that he/she doesn't know?

Does your child have difficulty saying what he/she wants to do, or do you have trouble understanding your child? Yes No  
If yes, please explain.

Children sometimes cry or get cranky when they are tired, hungry or sick. Does your child often cry or get upset at other times and you can't figure out why? Yes No If yes, please explain.

Does your child sometimes have trouble focusing or paying attention? Yes No If yes, please explain.

Have there been any recent changes in your family or daily routine that may affect your child and his/her behavior? Yes No  
If yes, please explain.

\* PIR question – must be answered by parent/guardian

At what point did your child do the following:  
Sit up without help \_\_\_\_\_ months  
Crawl \_\_\_\_\_ months  
Begin to use single words \_\_\_\_\_ months  
Begin to use sentences \_\_\_\_\_ years \_\_\_\_\_ months  
Walk \_\_\_\_\_ months  
Play with toys \_\_\_\_\_ months  
Feed him/herself \_\_\_\_\_ months  
Learn to use the toilet \_\_\_\_\_ years \_\_\_\_\_ months  
Dress him/herself \_\_\_\_\_ years \_\_\_\_\_ months  
Draw \_\_\_\_\_ years \_\_\_\_\_ months

Has your child received services from the Children's Services Division?  Yes  No If yes, please explain.

Do you have any concerns about your child's development?  Yes  No If yes, please explain.

\* PIR question – must be answered by parent/guardian

Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Head Start staff signature \_\_\_\_\_ Date \_\_\_\_\_