HEALTH/DEVELOPMENTAL HISTORY

INFORMATION CONTAINED IN THIS REPORT IS CONFIDENTIAL.
IT IS INTENDED FOR PROFESSIONAL STAFF TO USE IN WORKING WITH YOUR CHILD.

CHILD'S NAME: _____ AGE:_____ DATE OF BIRTH: _____ GRADE: _____

Please list **ALL** the members of the child's current household:

FULL NAME	RELATIONSHIP TO CHILD	DATE OF BIRTH	AGE

Please list **ALL** other brothers and sisters of the child who are not living at home:

FULL NAME	FULL/HALF/STEP SIBLING	DATE OF BIRTH	AGE

What is the language spoken in the home? _____

I. FAMILY MEDICAL HISTORY

A. Is there a family history of the following? (Please check those that apply):

	Father's Side	Mother's Side
1. Diabetes	____	____
2. Heart disease	____	____
3. Seizures	____	____
4. Asthma	____	____
5. High blood pressure	____	____
6. Respiratory problems	____	____
7. Blood disorders	____	____
8. Cancer	____	____
9. Genetic disorder	____	____
10. Hyperactivity	____	____
11. Impulsivity	____	____
12. Physical abuse/sexual abuse	____	____
13. Emotional abuse	____	____
14. Drug addiction	____	____
15. Alcohol problems	____	____
16. Emotional problems	____	____
17. Mental hospitalization	____	____
18. School learning problems	____	____
19. School behavioral problems	____	____
20. Speech/language problems	____	____
21. Special Education Services	____	____

COMMENTS:_____

B. Highest grade level completed by mother: _____ by father: _____

II. PREGNANCY AND BIRTH

A. PRENATAL

1. First saw doctor in _____ month of pregnancy.
2. Continued regular visits throughout pregnancy: _____ Yes _____ No
3. When child was born, mother was _____ years of age, father was _____ years of age.
4. This was mother's (give number) _____ pregnancy. Number of live births _____
5. How long was the pregnancy? _____ Months
6. Please check any conditions which applied to mother during pregnancy (Check as many as apply):

_____ Excessive weight gain	_____ Emotional problems	_____ Toxemia	_____ Seizures
_____ Excessive weight loss	_____ Loss of consciousness	_____ Diabetes	_____ Bleeding
_____ High blood pressure	_____ Rh incompatibility	_____ Cramping	_____ Illnesses
_____ Low blood pressure	_____ Viruses or infections	_____ Accidents	_____ Other
_____ Severe nausea/vomiting	_____ Required bedrest		

COMMENTS: _____

7. Was mother exposed to x-rays during pregnancy? _____ Yes _____ No
8. Did mother smoke during pregnancy? _____ Yes _____ No _____ Packs per day
9. Did mother drink alcohol during pregnancy? _____ Yes _____ No

Drinks per day _____ Type of alcohol: _____

10. Did mother take any of the following drugs/medication during pregnancy?

_____ Amphetamines (Speed)	_____ Heart medicine	_____ Cold remedies (Over the counter medicine)
_____ Tranquilizers	_____ Psychiatric medicine	_____ Prenatal or other vitamins
_____ Blood pressure medicine	_____ Aspirin	_____ Marijuana
_____ Insulin	_____ Tylenol	_____ Cocaine (Crack)
_____ Antiseizure medicine	_____ Antibiotics	_____ Heroine _____ Other

COMMENTS: _____

11. Did mother have problems with other pregnancies? Explain: _____

_____

B. PERINATAL

1. Was this child delivered in a hospital/clinic? _____ Yes _____ No

If no, where was the child born? _____

If yes, name of facility: _____ City/State/Country: _____

2. How long was labor? _____ Hours
3. Was labor: _____ Easy _____ Average _____ Difficult
4. Birth weight: _____ Pounds _____ Ounces Birth length: _____ Inches
5. Birth was: _____ Head first _____ Breech _____ Caesarean _____ Forceps needed _____ Vacuum extraction
6. Did baby cry immediately? _____ Yes _____ No
7. Did baby need oxygen? _____ Yes _____ No
8. Medical conditions baby had at birth (Check as many as apply):

_____ Bruises	_____ Blue baby	_____ Head trauma	_____ Cord around neck
_____ Infections	_____ Seizures	_____ Transfusions	_____ Bleeding problems
_____ Heart problems	_____ Surgeries	_____ Feeding problems	_____ Breathing problems
_____ Low birth weight	_____ Other		

COMMENTS: _____

9. Was baby jaundiced (yellow color) at birth? _____ Yes _____ No

Was baby put under special lights? _____ Yes _____ No

10. Did baby come home with mother? _____ Yes _____ No

If no, explain: _____

III. DEVELOPMENTAL HISTORY

A. Age at which child first

_____ Walked _____ Spoke in sentences _____ Successfully bladder trained _____ Successfully bowel trained

B. As a baby, did any of the following describe your child (Check as many as apply):

_____ Calm	_____ Happy	_____ Poor sleeper	_____ Colicky	_____ Had eating problems
_____ Cranky	_____ Cuddly	_____ Stiff	_____ Clumsy	_____ Failure to thrive/grow

COMMENTS: _____

C. Did you or anyone else have concerns that your child was not developing normally? _____ Yes _____ No

COMMENTS: _____

IV. CHILD'S MEDICAL HISTORY:

A. Name of child's pediatrician: _____

Date of last visit: _____ Date of last physical examination: _____

B. Has your child ever had? (Check as many as apply):

____ Frequent colds	____ Bedwetting	____ Rheumatic fever
____ Frequent ear infections	____ Toileting accidents	____ Heart problems
____ Tubes in ears	____ Frequent urination	____ Heart surgery
____ Hearing problems	____ Excessive thirst	____ Meningitis/encephalitis
____ Tonsillitis	____ Kidney disease or problems	____ Head injury
____ Tonsillectomy	____ Diabetes	____ Attention deficit disorder
____ Fever over 104	____ Hepatitis	____ Neurologic problems
____ Febrile seizures	____ Anemia	____ Mental problems
____ Seizure disorder	____ Blood disorders	____ Hernia
____ Frequent headaches/migraines	____ Ingestion of poison, toxic substance	____ Muscle problems
____ Vision problems/glasses	____ Tobacco use	____ Stitches
____ Asthma	____ Alcohol abuse	____ Broken bones
____ Allergies	____ Drug abuse	____ Surgeries
____ Skin disorder	____ Stomach problems	____ Hospitalizations
____ Chicken pox	____ Pregnancy	____ Genetic disorder
____ Thyroid disorder	____ Cancer	____ Immune suppression

IF YOU CHECKED ANY OF THE ABOVE, OR HAVE OTHER COMMENTS, PLEASE EXPLAIN BELOW:

DATE TYPE OF PROBLEM TREATMENT (PLEASE INDICATE IF ONGOING) HEALTH CARE PROVIDER

_____

_____

_____

_____

_____

_____

_____

_____

C. List current medications:

NAME OF MEDICATION DOSAGE HEALTH CARE PROVIDER NEEDED AT SCHOOL (YES/NO)

_____

_____

_____

_____

_____

D. Activity limitations. Please explain: _____

_____

_____

E. Special medical needs. Please explain: _____

_____

_____

F. ADDITIONAL COMMENTS AND CONCERNS: _____

_____

_____

NAME OF PERSON COMPLETING FORM: _____ DATE: _____

RELATIONSHIP TO CHILD: _____

CCSD PERSONNEL REVIEWING FORM: _____ TITLE: _____