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| **CHILD HEALTH RECORD – HEAD START PRESCHOOL PROGRAM** |  |
| Child's Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_ Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Person Interviewed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Name of Interviewer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
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| **Pregancy/Brith History** | **YES / NO** |
| 1. Did Mother have any health problems during this pregnancy or during delivery? |  |
| 2. Did mother visit physician fewer than two times during pregnacy? |  |
| 3. Was child born outside of a hospital? |  |
| 4. Was child born more than three weeks early or late? |  |
| 5. What was child's birth weight? |  |
| 6. Was anything wrong with child at birth? |  |
| 7. Was anything wrong with child in the nursery? |  |
| 8. Did child or mother stay in hospital for medical reasons longer than usual? |  |
| 9. Is mother pregnant now? |  |
| **Hospitalizations and illnesses** |  |
| 10. Has child ever been hospitalized or operated on? |  |
| 11. Has child ever had a serious accident (broken bones, head injuries, falls, burns, poisoning)? |  |
| 12. Has child ever had a serious illness? |  |
| **Health Problems** |  |
| 13. Does child have frequent \_\_sore throat, \_\_cough, \_\_urinary infections or trouble urinating, \_\_stomach pain, vomiting, diarrhea? |  |
| 14. Does child have difficulty seeing (squint, cross eyes, look closely at books)? |  |
| 15. Is child wearing (or supposed to wear) glasses? |  |
| 16. Does child have problems with ears/hearing (pain in ear, frequent earaches, discharge, rubbing or flvoring one ear? |  |
| 17. Have you ever noticed child scratching his/her behind while asleep? |  |
| 18. Has child ever had a convulsion or seizure? |  |
| Is Child taking medicine for seizures? |  |
| 19. Is child taking any other medicine now? (Special consent form must be signed for Head Start to administer any medication). |  |
| 20. Is child now being treated by a physician or a dentist? |  |
| 21. Has child had \_\_boils, \_\_chickenpox, \_\_eczema, \_\_german measles, \_\_mumps, \_\_scarlet fever, \_\_ whooping cough? |  |
| 22. Has child had \_\_hives, \_\_ polio? |  |
| 23. Has child had \_\_asthma, \_\_bleeding tencencies, \_\_diabetes, \_\_ epilepsy, \_\_heart, blood vessel disease, \_\_liver disease, \_\_rheumatic fever, \_\_sickle cell disease |  |
| 24. (If any 'yes' answers to questions 14,15,16,18,22 or 23 or 24) Do any of the conditions we've talked about so far, get in the way of the child's everday activities? Did a doctor or other health professonal tell you the child has this problem? |  |
| 25. Are there any conditions we haven't talked about that get in the way of the child's everyday activities? Did a doctor or any other health professional tell you the child had this problem? |  |
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