child & family SERVICES
STANISLAUS COUNTY OFFICE OF EDUCATION

Infant Health History

Birth – 1 year

Date: _____ Homebased/Center/FCCH:_____

Child's Name: _____

Parent Name: _____ Phone #_____

***Doctor's or Clinic Name/Address**:_____

_____

***Child's Insurance (Circle)** Medi-Cal Emergency Medi-Cal Only Healthy Families
Covered California Private/Other:_____

Prenatal and Birth History

1. Birth weight_____ Birth length _____
2. Was your baby:□ Early □ Late □ Full Term?
3. How many weeks was the pregnancy?_____
4. Were there any difficulties with labor?
   □ Yes □ No If yes, please explain:
   _____
   _____
   _____

At any time during this pregnancy, did the <u>mother</u>:

5. Have bleeding? □ Yes □ No
6. Have the flu or other infections? □ Yes □ No
7. Have persistent vomiting? □ Yes □ No
8. Need medications other than vitamins or iron? □ Yes □ No
9. Have high blood pressure? □ Yes □ No
10. Have other illnesses or accidents? □ Yes □ No
11. Use alcohol or illegal drugs? □ Yes □ No
12. Smoke? □ Yes □ No
13. Explain YES answers:
    _____
    _____
    _____

<u>Child's</u> Health History

14. Please circle any of the following that has happened with your baby:
    Eye problems Jaundice Fevers
    Infections Heart problems
    Skin conditions Jittery/shaky
    Problems breathing Trouble feeding
    Hospitalizations Other
    Explain anything you circled above:
    _____

<u>Child's</u> Medical Concerns

15. Did your child pass the newborn hearing screening? □ Yes □ No □ Don't Know
16. Has your child ever had an allergy/reaction to foods, medications, or immunizations?
    □ Yes □ No If yes, please explain:_____
    _____
    _____
17. Do you think your baby is in any way different from children of the same age? □ Yes □ No
    If yes, in what way?_____
    _____
    _____
    _____

18. List any medication your baby is currently taking, including vitamins, iron, over-the-counter and herbal medicines: _____

_____

19. If your baby is 2 months or older, at what age did he/she:

Smile or respond to smiles: _____	□ Not Yet
Roll over:_____	□ Not Yet
Sit alone:_____	□ Not Yet
Crawl: _____	□ Not Yet
Take 10 steps alone: _____	□ Not Yet
Babble:_____	□ Not Yet
Join words:_____	□ Not Yet
Make eye contact:_____	□ Not Yet

Nutrition:

20. Does your child have food restrictions? □ Yes □ No

If yes: □ Medical need (special diet prescribed by a doctor) Please explain:_____

□ Religious, cultural or personal reasons. Please explain:_____

21. Has your baby been diagnosed with any nutritional concerns (i.e. failure to thrive)? □ Yes □ No

If yes, please explain:_____

22. Do you feel your baby eats too much? □ Yes □ No

23. Do you feel your baby does not eat enough? □ Yes □ No

Dental

24. Does your baby take fluoride drops or drink fluoridated water? □ Yes □ No

25. Do you ever prop a bottle for your baby? □ Yes □ No

*26. **Do you have a <u>family</u> Dentist**? □ Yes □ No

***If yes, name of Dentist**:_____

*27. **Does your child have Dental Insurance**? □ Yes □ No

***If yes, name of Dental Insurance**:_____

Family History

28. Have any of your **child's** family members been diagnosed with any of the following conditions: Check box next to condition and write in family member (i.e. Mother, Father, Sibling, Grandparent, etc).

Condition	√	Family Member	Condition	√	Family Member
Asthma			Thyroid Disease		
Allergies			Kidney Disease		
Anemia			Seizures		
Blood Disorder			Migraines		
Cancer			Autism		
Diabetes			Depression/Anxiety		
High Cholesterol			Alcoholism/Substance Abuse		
High Blood Pressure			ADD/ADHD		
Heart Attack/Disease			Other, Please explain:		

Tuberculosis Risk Assessment

1. Were you or your child born outside of the United States: □ Yes □ No
   Where were you and/or your child born?_____
   Has your child ever traveled outside of the United States?
   If yes, □ Yes □ No
   Where did your child travel?_____
   With whom did your child stay?_____
   How long did your child travel?_____
2. Do you know if your child has been exposed to anyone with TB disease? □ Yes □ No
3. Do you know if your child has close contact with a person who has a positive TB skin test? □ Yes □ No

   If yes, please answer these questions:
   - Do you know if the person had active TB disease or latent TB infection? Circle all that apply:
     TB Disease (Symptoms) Latent Infection (No Symptoms) Don't know
   - When did your child last have contact with that person?_____
     _____
   - How is your child related to the person with TB disease or latent TB infection? Please explain:_____

4. Do you know if your child has been in contact with someone who has recently (within the last year) been in jail or in prison? □ Yes □ No

Lead Poisoning Screening

1. Is paint peeling or chipping on any part of your house, or another house where your child spends a lot of time? □ Yes □ No
2. Is your house being remodeled? □ Yes □ No
3. Has your child or anyone in your family been treated or monitored for lead poisoning (i.e. blood lead > 5)? □ Yes □ No
4. Does your child live with someone whose job or hobby involves exposure to lead (i.e. painting, soldering, automobile battery manufacturing or recycling, vehicle radiator repair, auto painting, or stained glass work)? □ Yes □ No
5. Do you or anyone else who lives with or cares for your child use any imported home remedies and imported cosmetics? Examples include: Alacon, Alkohi, Azarcon, Bali goli, Bint al zahab, Coral, Greta, Farouk, Ghasard, Kandu, Kohl, Liga, Litargirio, Lozeena, Pay-loo-ah, Sindoor, Surma or Maria Luisa. □ Yes □ No
6. Do you use pottery (ceramics, earthenware) that is old or has been bought outside the US for cooking, eating, drinking, or storing food? □ Yes □ No
7. Does your family buy canned food or packed candies from other countries? □ Yes □ No
8. Does your child eat dirt or clay or other non-food items? □ Yes □ No
9. Does your child or family frequently travel outside the U.S.? □ Yes □ No

_____ _____

Parent/Guardian Signature Date

HEAD START STAFF ONLY

Infant Needs/Assessment Received? □ Yes □ No

_____ _____ _____

Health History Reviewed by (Staff Name) **Title** **Date**

Handouts/Forms Given: _____

Follow-up Notes: _____

***Indicates items on PIR (COPA) data entry**