



Spokane Head Start/EHS HEALTH, DENTAL AND DIET HISTORY

Date _____

Child's name _____ Site _____ Room _____ a.m. p.m. full day

HEALTH HISTORY

Date of last well child exam ____/____/____ Birth date ____/____/____

Birth weight ____ pounds ____ ounces Month prenatal care started _____

Mother's health during pregnancy _____

Did your child have problems at birth? (i.e., jaundice, oxygen needed, didn't cry, etc.) _____

Please mark the following conditions that apply to your child with an "E" or "P" to indicate an Existing or Past condition.

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergic condition | <input type="checkbox"/> Bowel/bladder accidents | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Respiratory (A) | <input type="checkbox"/> Cancer (M) | <input type="checkbox"/> Heart trouble (C) |
| <input type="checkbox"/> Drugs (W) | <input type="checkbox"/> Constipation/diarrhea/food intolerance (B) | <input type="checkbox"/> Neurological problems (N) |
| <input type="checkbox"/> Foods (F) ¹ | <input type="checkbox"/> Diabetes (D) | <input type="checkbox"/> Seizures with/without fever (S) |
| <input type="checkbox"/> Insects (I) | <input type="checkbox"/> Eczema/skin condition (K) | <input type="checkbox"/> Serious accidents/injuries |
| <input type="checkbox"/> Latex (J) | <input type="checkbox"/> Eating/swallowing difficulties (E) | <input type="checkbox"/> Surgery/hospitalization |
| <input type="checkbox"/> Pollens/dust | <input type="checkbox"/> Exposure to TB/respiratory disease (R) | <input type="checkbox"/> Urinary tract infections (U) |
| <input type="checkbox"/> Anemia/sickle cell/blood disease (B) | <input type="checkbox"/> Hearing implants/aides/ear problems (H) | <input type="checkbox"/> Vision: wears glasses or patch (V) |
| <input type="checkbox"/> Bone/orthopedic (O) | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Other _____ |

Place an "X" here if any of the above conditions are LIFE THREATENING² and designate which one _____

Please explain items that are Existing _____

- Do you have any concerns about your child's health? No Yes If yes, what? _____
- Does your child take any medicine (vitamins, prescription or over the counter) on a regular basis? No Yes
If yes, what? _____
- Does your child have special needs or need help to participate in classroom activities (i.e., help with toileting, etc.)?
 No Yes If yes, what? _____

DENTAL HISTORY

Date of last dental exam ____/____/____ my child does not have a dentist

Has your child ever had any cavities? No Yes If yes, have they been fixed? No Yes

Does your child brush his/her teeth daily? No Yes

Do you help brush his/her gums/teeth? Always Sometimes Never

Does your child drink from a baby bottle or spill-proof cup at bedtime or naptime? No Yes If yes, content: _____

Do you have concerns about your child's teeth? No Yes If yes, explain _____

Do you have family dental concerns? No Yes If yes, explain _____

My child is currently enrolled in the ABCD dental program. No Yes

If not, I would like to enroll my child in the ABCD dental program. No Yes

I give my child systemic fluoride drops/tablets at home. No Yes

I choose not to give my child systemic fluoride. No Yes

Our family uses fluoride toothpaste, gels and/or mouthwash at home. No Yes

My child is too young for fluoride drops or tablets (less than six months of age).

¹ Give Special Diet Letter to parents
² Health specialist referral, when appropriate

PLEASE COMPLETE THE OTHER SIDE

DIET HISTORY

EVERYONE

Does your family restrict any foods for religious, cultural, ethical or personal reasons?

No Yes*** If yes, what foods and why? _____

Does your child have any chewing or swallowing problems?

No Yes* If yes, explain _____

Do you have any concerns about what your child eats or weighs?

No Yes*** If yes, explain _____

Is your child currently on WIC? No**** Yes If yes, which office? _____

Does WIC have any concerns about your child's growth or diet? No Yes If yes, what? _____

INFANT (breastmilk/formula; 0 to 4 months)

How do you feed your baby? Breast Bottle Both What do you put in the bottle? _____

Formula type used: Low iron** _____ With iron _____

Quantity consumed at one feeding? _____ Temperature of formula? _____

How often is the bottle offered? _____ Bottle type _____ Nipple type _____

Expresses hunger by _____

EXPLORER (introduction to solids; 4 to 12 months)

How do you feed your baby? Breast Bottle Both What do you put in the bottle? _____

Foods my baby has been offered: Cereal Fruits Vegetables Meats Other _____

Expresses hunger by _____ Type of cup used _____

How would you rate your child's appetite Good Poor***

TODDLER (table foods; 8 to 36 months)

How do you feed your baby? Breast Bottle Both What do you put in the bottle? _____

Foods my toddler has been offered:

Eggs Poultry Vegetables Bread Fruit Dairy products or milk

Fish Meat Cereal Rice Juice

How would you rate your child's appetite Good Poor***

PRESCHOOL (3 to 5 years)

How would you rate your child's appetite Good Poor***

Parent/guardian signature _____ Date _____

Updated form parent/guardian signature _____ Date _____

Updated form parent/guardian signature _____ Date _____

Reviewed by ed. staff

Reviewed by FSC

Reviewed by nurse consultant

Date/initial _____

Date/initial _____

Date/initial _____

* Nurse referral

** Children who do not receive high-iron formula or milk require a letter from their health care provider

*** Dietitian referral

**** WIC referral