

Child Health History

Child's Name: _____ **DOB:** _____

Pregnancy/Birth History

Original due date: _____ Initial prenatal visit: _____ months of pregnancy

Consistent prenatal care? Yes No

Prenatal Exposure? Yes No If YES, describe: _____

Baby born in hospital? Yes No Birth Weight: _____

Born on time? Yes No If NO: early by _____ weeks OR late by _____ weeks

Any concerns during pregnancy, labor, or delivery?

Any concerns at birth or in nursery?

Are you expecting? Yes No If YES, will a referral be made for Home-based services? Yes No

Health History Interview

Instructions: This section refers to PART I of the *CT Early Childhood Health Assessment Record*, which families complete at the time of the child's physical exam. If not completed, remind families to complete PART I before the enrollment visit.

For PART I "YES" answers regarding:	Explain/Describe:
Health concerns	
Allergies	
Daily medications	
Asthma	
Frequent or major illnesses or surgeries	
Lead poisoning/exposure	
Vision, hearing, speech, or communication concerns	
Movement or physical development concerns	
Sleeping, eating, or toileting concerns	
Activity level or weight concerns	
Behavior, social, or emotional development concerns	
Birth to Three or Preschool Special Education	
Other concerns	

Is follow up already in place for each of the above concerns? Yes No

If NO, briefly describe the plan for obtaining or arranging necessary follow up:

Dental History Interview

Does the child have a dental home?

Yes If YES, complete *Dental Refusal* No If NO, complete Dental Application

Dentist Name: _____ Date of last appointment: _____

Water: City Well

For city water:

At what age did child begin drinking city water
(or formula made with city water)?

Age: _____

For well water:

Has water been tested? Yes No Unsure

Does water contain fluoride? Yes No Unsure

Is family using only bottled water? Yes No

Is child using fluoride toothpaste? Yes No

****All families should receive "Dental Home by One" brochure and list of local dental providers****

Lead Risk Assessment

Instructions: For children 6 months and older: if lead screening **has not** been recorded on PART II of the child's physical, ask the questions listed below. If family answers YES or UNKOWN to any question, give lead poisoning screening information and refer family to health care provider for testing.

1. Does your child live in or regularly visit a house built before 1978? Yes No
2. Does your child have a brother or sister, housemate, or playmate being followed or treated for lead poisoning? Yes No
3. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? (Examples: construction, welding, automotive repair shop, other trades, stained glass making; using lead solder, artist paints or ceramic glazes; etc.) Yes No
4. Has your child been exposed to any imported products (spices, foods/vitamins, ethnic home remedies, or ethnic cosmetics)? (Examples include: azarcon (also known as rueda, Maria Luisa, alarcon, liga); albayalde; greta; pay-loo-ah; ghasard; bala goli; kandu; kohl; litargirio; bebetina; chyawan prash.) Yes No

NOTE: According to CT DPH guidelines, if the answer to any of the above questions is YES or UNKNOWN, then the child is considered to be at risk and should be tested.

Safety Assessment

Instructions: Review the following with families and provide additional educational information or resources as needed.

Are the following safety precautions in place?	YES	NO	Comments
Child proof home/poisons locked			
Helmets			
Car Restraints			
Fire Safety			
Guns/weapons locked			

Parent/Guardian Name: (print) _____ (sign) _____

Date: _____

FA/HV Initials: _____ Interviewed: _____ Date: _____

Permission to post information about child's health care needs, allergies, including food, insects, medications: Yes No NA

Parent/Guardian Initials: _____

Reviewed by Health Manager:

Signature _____

Date _____