

CHILD'S PREADMISSION HEALTH HISTORY – PARENT'S REPORT

Child's Name:	Sex:	Date of birth
Father's name:	Age:	Does the father live at home with child?
Mother's name:	Age:	Does the mother live at home with child?
Has the child been under regular supervision of a physician?		Date of last examination:

DEVELOPMENTAL HISTORY

Walked at: _____ months Began talking at: _____ months Toilet training started at: _____ months

ILLNESSES – Check all illnesses that the child has had and give approximate dates:

<input type="checkbox"/> Chicken Pox	-Dates-	<input type="checkbox"/> Diabetes	-Dates-	<input type="checkbox"/> Poliomyelitis	-Dates-
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-day measles (Rubeola)	
<input type="checkbox"/> Rheumatic fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-day measles (Rubella)	
<input type="checkbox"/> Hay fever		<input type="checkbox"/> Mumps			

Other serious illnesses or accidents: _____

Does the child have frequent colds? _____ How many in the last year? _____

List any allergies the staff should be aware of: _____

DAILY ROUTINES

What time does the child get up?	What time does the child go to bed?	Does the child sleep well?
Does the child sleep during the day?	When?	How long?
Diet Pattern	Breakfast	What are usual eating hours?
	Noon meal	Any eating problems?
	Evening meal	Any food dislikes?

Are bowel movements regular? Yes ____ No ____ What is the usual time? _____

Word used for - Bowel movement: _____ Urination: _____

Parent's evaluation of child's health

Parent's evaluation of child's personality

How does the child get along with parents, brothers, sisters, and other children? _____

Has the child had group play experiences?

Does the child have any special problems or fears? (Explain.) _____

Parent Signature	Date
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