Community Colleges of Spokane

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 **E**xisting or **P**ast condition.

____ Allergic condition
- ____ Respiratory (A)
- ____ Drugs (W)
- ____ Foods (F)[1]
- ____ Insects (I)
- ____ Latex (J)
- ____ Pollens/dust

____ Anemia/sickle cell/blood disease (B)

____ Bone/orthopedic (O)

____ Bowel/bladder accidents

____ Cancer (M)

____ Constipation/diarrhea/food intolerance (B)

____ Diabetes (D)

____ Eczema/skin condition (K)

____ Eating/swallowing difficulties (E)

____ Exposure to TB/respiratory disease (R)

____ Hearing implants/aides/ear problems (H)

____ Hepatitis C

____ HIV

____ Heart trouble (C)

____ Neurological problems (N)

____ Seizures with/without fever (S)

____ Serious accidents/injuries

____ Surgery/hospitalization

____ Urinary tract infections (U)

____ Vision: wears glasses or patch (V)

____ Other _____

❒ **Place an "X" here if any of the above conditions are LIFE THREATENING[2]** and designate which one

_____

Please explain items that are **E**xisting _____

_____

1. Do you have any concerns about your child's health? ❒ No ❒ Yes If yes, what? _____
2. Does your child take any medicine (vitamins, prescription or over the counter) on a regular basis? ❒ No ❒ Yes
   If yes, what? _____
3. 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 - Infants Only

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*