Duluth Preschool Health and Nutrition History

Child's Last Name | First Name | Middle | Date of Birth | ❑ Male ❑ Female

PREGNANCY / BIRTH:

During pregnancy with this child, mother had:

- ❑ Anemia
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/ Seizures
- ❑ Heart Condition
- ❑ Rh Incompatibility
- ❑ Urinary Tract Infection
- ❑ Vaginal Bleeding/infections
- ❑ Toxemia/ High Blood Pressure/ Swollen Ankles
- ❑ Pre Term Labor
- ❑ Other: please describe _____

The following were used during pregnancy: ❑ Alcohol ❑ Street Drugs ❑ Tobacco products

AT BIRTH, MY CHILD WEIGHED: _____lbs _____oz

❑ Had difficulties during labor, delivery, or shortly after birth

Growth and Development

Sat without support at age: _____ months
Walked without assistance at age: _____ months or years
Spoke in two word sentences at age: _____ months or years

SPECIAL NEEDS AND HEALTH CONCERNS :

Does your child have any medical diagnoses?
List_____
Does your child require any classroom accommodations? Explain

Does your child have any allergies? Explain

Does your child have physical limitations or special equipment? Explain

Is your child receiving any therapy or special education services of any kind? Explain

FOOD PROGRAMS: Check any programs you take part in

❑ WIC for Children ❑ SNAP ❑ Other_____

EATING HABITS :			Explain
My child requires a special diet	❑ Yes	❑ No	_____
My child's diet has religious/cultural guidelines	❑ Yes	❑ No	_____
I am concerned about my child's eating habits	❑ Yes	❑ No	_____
I am concerned about my child's height	❑ Yes	❑ No	_____
I am concerned about my child's weight	❑ Yes	❑ No	_____
I give my child vitamins (if yes, how often?)	❑ Yes	❑ No	_____
Overall, my child's appetite is	❑ Good	❑ Fair	❑ Poor

One thing I like best about my child's eating habits is:

In the classroom, I prefer my child receives:
❑ Cow's milk ❑ Lactose free cow's milk ❑ Soy milk
❑ Water Other_____

One thing I'd like to change about my child's eating habits is:

My child drinks from:
❑ Baby bottle ❑ Sippy cup ❑ Cup

Typical snacks for my child are:

Check the box that describes what you do or how you feel most of the time	Almost Always	Sometimes	Almost Never
I consider my child to be a picky eater	❑	❑	❑
I sit with my child when he/she is eating	❑	❑	❑
I make my child eat what is on his/her plate	❑	❑	❑
I serve only what I know my child will eat	❑	❑	❑
My child eats whenever he/she wants	❑	❑	❑
My child gets food from the fridge/cupboard when he/she wants	❑	❑	❑
Meal times are pleasant with my child	❑	❑	❑

INFANTS AND CHILDREN YOUNGER THAN 3 YEARS OF AGE: My baby drinks _____ ounces of milk per day		
My baby is allowed to go to sleep with the bottle	❑ Yes	❑ No
My baby is fed more than 10 ounces of full strength juice a day	❑ Yes	❑ No
Solids were offered to my baby before they were 7 months old	❑ Yes	❑ No
My baby takes medications, vitamins, herbs not prescribed by my doctor	❑ Yes	❑ No
My baby has missed a scheduled doctor's appointment	❑ Yes	❑ No

FAMILY HISTORY

Do you or any of your family have a chronic disease such as:

- ❑ Cancer
- ❑ Hemophilia
- ❑ Sickle Cell Anemia
- ❑ Muscular Dystrophy
- ❑ Cysitc Fibrosis
- ❑ Other: _____

CHILDHOOD ILLNESSES: Child has or has had:

- ❑ Chicken pox
- ❑ Diabetes
- ❑ German Measles / Rubella
- ❑ Strep
- ❑ Scarlet Fever
- ❑ Meningitis
- ❑ Whooping Cough (Pertussis)
- ❑ Other Illness, please list _____

HEAD, EYES, EARS, NOSE AND THROAT: Child has or has had:

- ❑ Trouble with vision
- ❑ Glasses
- ❑ History of eye infections
- ❑ Trouble hearing
- ❑ Earaches / Discharge from ear
- ❑ Ventilation (PE) tubes put in ears: Date:_____
- ❑ A serious accident resulting in head injury

DENTAL: Child has or has had:

- ❑ Teeth brushed daily or brushes own teeth daily
- ❑ Dental sealants placed on 1 or more teeth
- ❑ Toothaches / Cavities / Damaged Teeth (circle)
- ❑ Trouble with mouth or gums

Fluoride from:

- ❑ Dental office treatment
- ❑ Mouth Rinses/ Tablets / Drops
- ❑ Toothpaste
- ❑ Vitamins

Source of water in our home is

- ❑ City
- ❑ Private Well / Rural Water System
- ❑ Bottled

CARDIO VASCULAR / RESPIRATORY / ALLERGIES/ SKIN PROBLEMS

- ❑ Hands or feet turn blue / tires easily
- ❑ Heart Trouble/ Murmur
- ❑ Asthma
- ❑ Severe Reaction to Insect Stings
- ❑ Problems with Rashes
- ❑ Eczema
- ❑ Hives
- ❑ Other_____

ASTHMA TRIGGERS / ASTHMA MEDICATIONS :

- ❑ Allergies
- ❑ Exercise
- ❑ Cold Air
- ❑ Smoke
- ❑ Pollen
- ❑ Scented Products
- ❑ Infection
- ❑ Stress
- ❑ Other_____
- ❑ Child experiences wheezing/ shortness of breath
- ❑ Child requires Asthma Medication at school

TUBERCULOSIS: Child or other family member has the following symptoms:

(Persons with any of these symptoms may be referred for a Mantoux test and evaluation by a physician)

❑ Child ❑ Family Member

- ❑ Chronic cough (coughing up phlegm) lasting longer than 1 month
- ❑ Coughing up blood.
- ❑ Recent unexplained weight loss
- ❑ Loss of appetite for more than 1 month
- ❑ Chronic fatigue/ very low energy for more than 1 month
- ❑ Chronic low grade fever for more than 1 month
- ❑ Night sweats (drenching sweats occurring during the night)

My family has

- ❑ Recently moved to Duluth from _____
- ❑ Recently lived in a homeless shelter
- ❑ Recently been in contact with a person with known Tuberculin infection

TOILETING / GASTROINTESTINAL: Child has or has had:

- ❑ Trouble with daytime / nighttime wetting
- ❑ Kidney or Bladder Infections
- ❑ Soils pants with bowel movement
- ❑ Trouble with constipation

SKELETAL / NEUROMUSCULAR: Child has or has had:

- ❑ Complains of pains in arms, legs, back or joints
- ❑ Limps or walks with toes in or toes out
- ❑ A broken bone, cast, brace or corrective shoe
  Explain: _____
- ❑ Some unexplained movements or jerks
- ❑ Staring spells
- ❑ Convulsions / seizures

LEAD: Child has or has had:

- ❑ Blood test for lead. Circle Results: NORMAL / ELEVATED
- ❑ Sibling or playmate with lead poisoning
- ❑ Lives or visits regularly in a house built before 1975
- ❑ Eats/chews on non-food items (wood work, pencils, paint chips, crib plaster, paper, cigarettes, clay, soil)
- ❑ A member of household who works in a lead industry (automobile batteries, lead piping, etc)
- ❑ Plays on grounds or lives near possible lead contaminated areas (heavy traffic, hazardous waste site, lead smelter, processing plant, site of demolished old building)

Parent/Guardian Signature:_____ **Date:**_____

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