Family Health Network of CNY – School Health Program
Child Health Record - Initial History

Your son's/daughter's health is important to us. In order for us to have a better understanding of his/her past and present medical history, we request that you complete the following questionnaire. Thank you for your time and cooperation.

Date _____ **Student's Name** _____ Male Female

Date of Birth _____ **SS#** _____

I. Pregnancy/Birth History

1. Where did you have health care for your pregnancy?
   _____
   (Provider's name) (Place) (Starting in what month of pregnancy)
2. Name of hospital son/daughter was born in _____
3. During your pregnancy did you:
   a. Take any medication? ☐ No ☐ Yes (if Yes, please explain what kind and how long)
   _____
   b. Have any illness or problems? ☐ No ☐ Yes (if Yes, please explain)
   _____
   c. Use any tobacco, drugs, or alcohol? ☐ No ☐ Yes (if Yes, please explain)
   _____
4. Was this child born: ☐ Vaginally ☐ Emergency C-Section ☐ Repeat C-Section
5. Was this child: ☐ Premature (how many weeks premature)_____
   Birth weight _____ Length _____ Apgar (if known) _____
6. Any problems at birth (with this child) ☐ No ☐ Yes (if Yes, check any that apply and explain)
   ☐ Color _____ ☐ Kidney _____
   ☐ Rash _____ ☐ Bowels _____
   ☐ Breathing _____ ☐ Birth defects _____
   ☐ Skin _____ ☐ Other _____
   ☐ Infection _____ _____
7. Did any problems develop after birth? ☐ No ☐ Yes (if Yes, check all that apply and explain)
   ☐ Breathing _____ ☐ Seizures _____
   ☐ Feeding _____ ☐ Infection _____
   ☐ Jaundice (turned yellow) _____
   ☐ Heart problem/murmur _____
   ☐ Other _____
   ☐ Any other information _____
8. Did your baby go home with you? ☐ Yes ☐ No (if No, please explain why not)
   _____

II. Feeding

1 Do any foods bother this child? ☐ No ☐ Yes (if Yes, please explain) _____
2 Does this child take vitamins? ☐ No ☐ Yes (if Yes, what kind and how much)_____
3 Does this child take fluoride? ☐ No ☐ Yes (if Yes, what kind and how much) _____
4 Does this child have any food allergies? ☐ No ☐ Yes (if Yes, list to what and explain) _____
5 Is this child on any special diet? ☐ No ☐ Yes (if Yes, please explain) _____
6. Is this child a picky eater? ☐ No ☐ Yes (if Yes, please explain) _____

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III. Growth Development

1. Did this child:
   Sit alone by 7 months ☐ No ☐ Yes (if No, explain) _____
   Walk alone by 15 months ☐ No ☐ Yes (if No, explain) _____
   Say words by 18 months ☐ No ☐ Yes (if No, explain) _____
   Toilet trained by 3 years ☐ No ☐ Yes (if No, explain) _____

2. Did any medical provider ever tell you that this child's height or weight was not normal for his/her age? ☐ No ☐ Yes (if Yes, please explain) _____

3. Does this child have any problems with or do you have concerns about:
   a. Sleeping habits (nightmares, night terrors, etc) ☐ No ☐ Yes (if Yes explain)
   _____
   b. Eating ☐ No ☐ Yes (explain) _____
   c. Weight gain or weight loss ☐ No ☐ Yes (explain)
   _____
   d. Growth (height) ☐ No ☐ Yes (explain)
   _____
   e. Getting along with other children ☐ No ☐ Yes (explain)
   _____
   f. School performance ☐ No ☐ Yes (explain)
   _____
   g. Behavior (lack of control, overactive, doesn't listen) ☐ No ☐ Yes (explain) _____
   _____
   h. Habits (thumb sucking, head banging, nail biting, frequent unusual behaviors, eating non-food items etc.)
   ☐ No ☐ Yes (explain) _____
   i. Any other concerns ☐ No ☐ Yes (explain) _____
   _____

4. Last dental visit date _____

IV. Childhood Illness

1. Has this child ever had or does he/she presently have:

NO **YES** (if Yes, explain)

☐ ☐ Frequent ear infections _____
☐ ☐ Difficulty hearing _____
☐ ☐ Eye problems (crossed eyes, squinting) _____
☐ ☐ Wears glasses _____
☐ ☐ Heart condition/murmur _____
☐ ☐ Asthma _____
☐ ☐ Pneumonia _____
☐ ☐ Stomach/Intestinal problems _____
☐ ☐ Urinary/Kidney problems _____
☐ ☐ Bed wetting/stool soiling _____
☐ ☐ Seizures _____
☐ ☐ Frequent headaches _____
☐ ☐ Frequent/ongoing skin rashes/condition _____
☐ ☐ Anemia (low iron) _____
☐ ☐ Bleeding problems _____
☐ ☐ Frequent swollen glands _____
☐ ☐ Chicken Pox (varicella) illness. When? _____
☐ ☐ Measles, mumps, or German measles (the illness) _____
☐ ☐ Broken bones _____
☐ ☐ Serious accident _____
☐ ☐ Operation(s), please list _____
☐ ☐ Hospitalization, if Yes, when _____ What for _____
☐ ☐ Any allergies. List to what and reactions _____
☐ ☐ Other _____
_____

2. Is this child presently under a specialist's care? ☐ No ☐ Yes (if Yes, explain) _____

3. Is this child presently taking any medication including over the counter medication? ☐ No ☐ Yes

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(if Yes) What kind? _____ How much _____

4. Any other medical problems? ☐ No ☐ Yes (if Yes, explain) _____

_____

V. Immunizations (please give us a copy of this child's immunization record)

1. Has this child ever had a reaction to an immunization? (high fever, uncontrollable crying, seizures, etc)
   ☐ No ☐ Yes (if Yes explain) _____
2. Has this child had a TB screening test? ☐ No ☐ Yes – When? _____ Result? _____
3. TUBERCULOSIS RISK ASSESSMENT SCREENING TOOL
   Please circle one answer for each question.

YES **NO** **1.** Has this child had recent close contact with someone who has infectious tuberculosis or a positive skin (PPD) test?

YES **NO** 2. Has this child had an abnormal chest x-ray suggestive of TB?

YES **NO** 3. Is this child HIV positive? Or has he/she been exposed to adults who are HIV positive, IV drug users, homeless, incarcerated, or migrant workers?

YES **NO** 4. Has this child ever had an organ and/or bone marrow transplant or been on any immunosuppressive drugs?

YES **NO** 5. Has this child had an unusual persistent, productive cough; specifically coughing up thick material for more than three weeks or coughing up blood?

YES **NO** **6**. Has this child spent more than 30 consecutive days outside the US? If yes, where_____?
When _____?

VI. Family History

Check all applicable illnesses/diseases for each family member:

Family Member	Asthma	Diabetes	Cancer	Heart Disease	Hypertension	Genetic Disease	Hepatitis B	Hepatitis C	Mental Illness	Seizures	HIV	Tuberculosis	Alcohol/Drug Abuse	Anxiety	Depression	ADD/ADHD	Age at Death	If deceased, cause of death
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Maternal Grandmother (mother's mother)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Maternal Grandfather (mother's father)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Paternal Grandmother (father's mother)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Paternal Grandfather (father's father)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Mother's brother/sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Father's brother/sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Brother/Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Other _____																		

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VII. Environmental

1. Do you live in a: ☐ House ☐ Apartment ☐ Trailer ☐ Other _____
2. Type of heating _____
3. Water source _____ Fluoridated ☐ No ☐ Yes
4. Smokers in the home ☐ No☐ Yes
5. Who lives in the home?

Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age
Name	Relationship	Age

6. PATIENT RISK ASSESSMENT FOR LEAD TESTING
   Please circle one answer for each question.

YES **NO** 1. Do you live in and/or regularly visit a house or child care facility built before 1950?

YES **NO** 2. Do you live in a house built before 1978 that is undergoing renovations or has chipping/peeling paint?

YES **NO** 3 Does this child have a brother or sister, housemate, or playmate being followed or ever treated for lead poisoning?

YES **NO** 4. Does this child frequently come in contact with an adult who has a job or hobby that involves exposure to lead? (e.g. house painting, construction, welding, battery recycling, lead smelting, jewelry or pottery making)

YES **NO** 5 Does your family use traditional medicine, health remedies, cosmetics, powders, spices, or foods from other countries? (e.g. alkohl, azarcon, bala goli, ghasard, greta, pay-loo-ah, DawTway, DawKyin, dhavana, or shakti)

YES **NO** 6. Does this child eat non-food items (pica)? Does your child put things in their mouth such as toys, jewelry, or keys?

YES **NO** 7. Does your family cook, store, or serve food in lead, crystal, pewter, or pottery from Asia or Latin America?

YES **NO** 8. Have you lived in or spent time $\geq$ 2 months in an area outside of the USA?

Any special concerns regarding this child? ☐ ☐ Yes - If yes, explain _____

_____

_____

If you have any questions regarding this child's health or if you would like an appointment for a physical examination for this child done at the school, please call the Student Medical Services office.

DeRuyter Central School	(315) 852-3400 x8
Appleby Elementary School	(607) 849-3180
Marathon Jr./Sr. High School	(607) 849-3900
Cincinnatus Central School	(607) 863-3200 x2 x2

THANK YOU FOR YOUR COOPERATION!

THE SCHOOL HEALTH PROGRAM STAFF

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