Health/Nutrition History

Name _____ Birthday _____ Location _____

Assessment Results

Assessment Date | Assessed By | Assessment Results

- ☐ No Concerns
- ☐ Concern Identified

Pregnancy/Birth History

Did mother have any health problems during this pregnancy or during delivery? (Infections, Complications, High Blood Pressure , Diabetes, Other Complications)

- ☐ Yes
- ☐ No

Pregnancy/Delivery Notes

Was child born more than 3 weeks early or late?

- ☐ Yes
- ☐ No

Child's Birth Weight | # Pounds | # Ounces

Was anything wrong with child at birth?

- ☐ Yes
- ☐ No

Describe complications.

Is Mom pregnant now?

- ☐ Yes
- ☐ No

Due Date:

Hospitalizations and Illnesses

Has child ever been hospitalized or operated on?

- ☐ Yes
- ☐ No

Hospital Name | Hospitalization Date

Explain reason for hospitalization.

Has child ever had a serious accident (Broken bones, head injuries, falls, burns, poisoning)?

- ☐ Yes
- ☐ No

Has child ever had a serious illness?

- ☐ Yes
- ☐ No

Explain any serious accidents or serious illnesses child may have had.

Health Problems

When did your child last see a doctor? Doctor Name Health Concern

☐ Is this child's Medical Home?

When did your child last see a dentist? Dentist Name Dental Concern

☐ Is this child's Dental Home?

Does your child have frequent: ☐ Sore Throats ☐ Cough ☐ Urinary Infections or Trouble Urinating

☐ Stomach Pain, Vomiting, Diarrhea or Constipation? ☐ Runny Nose/Seasonal Allergies

Other?

Is child wearing (or supposed to wear) glasses? When did your child last receive an eye exam?

☐ Yes
☐ No

Optometrist/Ophthalmologist Name

Does child have problems with ears/hearing (Pain in ear, frequent earaches, discharge, rubbing or favoring one ear)?

☐ Yes
☐ No

Describe hearing problems/surgeries.

Has child ever had a convulsion or seizure? Date of Last Seizure

☐ Yes
☐ No

Is child taking medicine for seizures? Seizure Medicine Name Prescribing Doctor for Seizure Medicine

☐ Yes
☐ No

Is child taking any other medicine now? Prescriptions, over-the-counter, and herbal medication your child takes regularly or as needed.

- [ ] Yes
- [ ] No

Please list additional medicine taken regularly or as needed AND frequency taken.

Has child been diagnosed with:	Asthma	Diabetes	Epilepsy	Eczema	Sickle Cell Disease	a Heart Condition?
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Other:

Has child been diagnosed with allergies?

- [ ] Yes
- [ ] No

Does the child take medication related to the allergies?

- [ ] Yes
- [ ] No

Name of Allergy Medication

Does the child have an EPI Pen?

- [ ] Yes
- [ ] No

Prescribing Doctor for EPI Pen

List foods, medication or environmental allergies and what reaction the child has (hives, itching, swelling, difficulty breathing, sneezing)

Developmental Concerns

Has child been evaluated by First Steps?

- [ ] Yes
- [ ] No

First Steps Evaluation Date

Is child currently receiving First Steps services?

- [ ] Yes
- [ ] No

Explain First Steps Services Provided.

Psychological and Social Development

Have there been any big changes in your child's life in the last six months?

- [ ] Yes
- [ ] No

Describe any big changes in your child's life in the last 6 months.

Are you or your family having any problems now that might affect your child?
- [ ] Yes
- [ ] No

Describe any family problems now that might affect your child.

Lead Screening

Is your child's lead level currently being monitored by a doctor or health professional?
- [ ] Yes
- [ ] No

Has your child been tested or treated for Lead Poisoning?
- [ ] Yes
- [ ] No

If "Yes", please list doctor or health professional who performed test.

If "Yes", please list test results - concerns or no concerns.

Does your child live in or regularly visit a house/building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling?
- [ ] Yes
- [ ] No

Does your child have a brother, sister, housemate or playmate who is being treated for lead poisoning?
- [ ] Yes
- [ ] No

Has your family/child ever lived outside the United States or recently arrived from a foreign country?
- [ ] Yes
- [ ] No

Have you seen your child eat paint chips?
- [ ] Yes
- [ ] No

Have you seen your child eat soil or dirt?
- [ ] Yes
- [ ] No

Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead? Note: Jobs include house painting, plumbing, renovation, construction, auto repair, welding, electronics repair, jewelry or pottery making. Hobby examples are making stained glass or pottery, fishing, making or shooting firearms and collecting lead or pewter figurines.
- [ ] Yes
- [ ] No

Does your family use products from other countries such as health remedies, spices, food, or store or serve food in leaded crystal, pottery or pewter?
- [ ] Yes
- [ ] No

Federal CMS regulations mandate lead testing, which is required at 12 and 24 months. If not tested prior, refer child to their local health department or medical home for testing. Was child referred for lead testing?

☐ Yes
☐ No

Nutrition History

Does your child have any food allergies, intolerances, or special formulas as prescribed by a physician or dietitian?

☐ Yes
☐ No

☐ If YES, then the Medical Statement for Children with Disabilities and Special Dietary Needs form is required.

If YES, describe child's food allergies, intolerances, or special formulas as prescribed by a physician or dietitian.

Does your child require any medications (antihistamines, Epi pens, etc) for any of the above nutrition concerns at school?

☐ Yes
☐ No

If YES, describe ANY medications (antihistamines, Epi pens, etc) for any of the above nutrition concerns at school.

Is your child restricted from foods due to religious, personal or cultural beliefs?

☐ Yes
☐ No

If YES, describe foods restricted due to religious, personal or cultural beliefs.

☐ Does your child receive WIC? ☐ Does your family receive SNAP?

Do you have any concerns about your child’s eating, drinking or nutrition?

☐ Yes
☐ No

If YES, describe any concerns about your child’s eating, drinking or nutrition.

Hunger Vital Sign™

Within the past 12 months, we worried whether our food would run out before we got money to buy more.

- ☐ <Select One>
- ☐ Often True
- ☐ Sometimes True
- ☐ Never True
- ☐ Don't Know/Refused

Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

- ☐ <Select One>
- ☐ Often True
- ☐ Sometimes True
- ☐ Never True
- ☐ Don't Know/Refused

EHS ONLY:

Which source of milk does your child currently receive? ☐ Breast Milk ☐ Formula ☐ Whole Milk ☐ Other

Please specify type of formula and/or OTHER source of milk your child currently receives.

Acceptance of Responsibility

- ☐ I understand that I am responsible for updating OVEC Head Start/Early Head Start of any changes in my child's food allergies
- ☐ EHS ONLY - I understand that I am responsible for reporting all foods introduced to the OVEC Early Head Start staff

Parent Name (PRINT)

Parent Signature | Date

Staff Signature | Date