Health History for Infants and Toddlers

Summit Early Learning Center, Inc.
Minneapolis, MN 55405
Phone: 612-377-9011 Fax: 612-977-0168

Child's Name _____ Birth Date: _____

Section A: Health History

1. Does this child seem well most of the time? Yes No

2. Is child taking any medications now (including aspirin, laxatives, vitamins, etc.)? Yes No
   If yes, what? _____ Why? _____

3. In the last year, has this child had as many as three (3) ear infections? Yes No

4. In the last year, has this child had more than three (3) colds or sore throat infections with a fever? Yes No

5. Does your child have any handicaps/special needs? Yes No
   If yes, please describe: _____

6. Other illnesses or diseases? Yes No
   If yes, what? _____

7. Has this child been hospitalized? Yes No
   Describe: _____

8. Has this child had any serious accidents or poisonings? Yes No
   Describe: _____

9. Does this child chew unusual things like pencils, chalk, cribs, window ledges, paint chips, plaster or hair? Yes No

10. Has your child had any of the following? Select any that apply:
    Premature birth Birth injury or defect Trouble breathing at birth Convulsions/seizures Head Injury
    Allergies: eczema, hives, drug/food intolerance, hay fever, wheezing, asthma, insect stings
    Explain: _____

Section B: Developmental History

1. How do you comfort your child? _____
2. What are your child's favorite toys? _____
3. What are your child's favorite activities? _____
4. What language is spoken at home? _____

Health History for Infants and Toddlers continued

Summit Early Learning Center, Inc.
Minneapolis, MN 55405
Phone: 612-377-9011 Fax: 612-977-0168

Child's Name _____ Birth Date: _____

Section C: Sleeping History

1. Do you have any special way of helping your child go to sleep? Yes No
   If so, what? _____
2. Does your child cry when going to sleep (infants only)? Yes No
3. What is your child's present sleeping schedule? _____
4. Does your baby (infants only) prefer to sleep on his/her: ☐ Stomach ☐ Side ☐ Back
5. Does your child need a pacifier (infants only)? Yes No
6. Does your baby need a blanket? Yes No
7. Does your baby need a special toy/stuffed animal? Yes No

Section D: Feeding History

1. Is your infant: Breast Fed or Bottle Fed
2. Type of: Bottle _____ Formula _____
3. What is your child's present eating schedule? (Specify amount and time for milk, formula, juice, food, etc.)
   Describe: _____
4. Has your child had any feeding problems?
   If yes, describe: _____ Yes No

Section E: Toileting History

1. How often does your child have a bowel movement (B.M.) _____
2. Is your child toilet trained? Yes No
3. What word does your child use for urination? _____
4. What word does your child use for B.M.? _____
5. Does he/she use a potty chair? Yes No
6. Does your child frequently have diaper rash? Yes No
7. How do you treat his/her diaper rash? _____

Parent's Signature _____ Today's Date _____