## CHILD HEALTH AND DEVELOPMENTAL HISTORY (3-5 YEARS)

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Male</th>
<th>Female</th>
<th>Birth Date</th>
<th>Age</th>
<th>(For office use only) Child/Student MARSS ID or Record #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Name</td>
<td>Phone ( ) -</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>Zip</td>
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</tbody>
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Who lives with your child? ____________________________________________

Language(s) spoken in the home ________________________________________

How often does your child see a doctor or nurse? # of visits/year
How often does your child see a dentist? # of visits/year

Do you have health insurance? □ yes □ no

Insurance provider________________________________________ Group #_______________________________

Do you have questions or concerns about your child? We can talk about them today.

Please list your concerns: ____________________________________________

Please describe your child’s special needs and strengths: __________________________

Please check the boxes if you or your child use:

- Child and Teen Checkups
- Follow-Along Program
- Early Childhood Family Education (ECFE)
- Head Start
- WIC
- School Readiness
- Parenting Education
- Food Pantries

Please check the box(es) if you have concerns or questions about your child’s:

- □ health
- □ learning
- □ behavior
- □ talking
- □ growth
- □ skin/bruising, rashes
- □ eyes/vision
- □ ears/hearing
- □ nose
- □ throat
- □ teeth
- □ mouth
- □ stomach
- □ toileting
- □ activity level
- □ walking/balance
- □ social (friends)
- □ feelings/moods
- □ breathing/coughing
- □ headaches
- □ general appearance
- □ other__________

Please check the box(es) that apply to your child and explain:

- □ allergies to foods and/or medicines
- □ takes medicines, herbs, and/or vitamins
- □ visits to health specialists
- □ serious illnesses
- □ serious injuries or loss of consciousness
- □ hospital stays and/or surgeries
- □ problems during mother’s pregnancy or birth
- □ at birth, stayed in the hospital longer than mother
- □ Members of the same family sometimes have the same health problems. Please list family health problems:

Over please.
### Eating Habits

Please check all box(es) that describe your child:

- □ drinks from a cup
- □ drinks from a bottle
- □ on a special diet

Every day, eats some foods from these food groups:

- □ fruits (oranges, apples, bananas, mangos, tomatoes)
- □ vegetables (spinach, corn, peas, potatoes, cabbage)
- □ milk, cheese, yogurt, tofu
- □ bread, cereal, rice, tortillas, crackers, pasta
- □ meat, fish, poultry, peanut butter, beans, legumes, eggs
- □ cookies, cakes, candy, pie, butter, fried foods

Every day, drinks:

- □ milk
- □ juice
- □ fruit drinks
- □ formula
- □ kool-aid
- □ water
- □ pop

### Home

Please check all boxes that describe your child:

- □ 1950
- □ 1978 and is being remodeled

Does your child live or play in a home or building built before:

- □ use tobacco
- □ use alcohol
- □ have a gun

Does anyone in your home or who cares for your child:

- □ violence
- □ street drugs
- □ unsafe conditions

Is your child exposed to:

- □ lead poisoning
- □ other child rearing issues
- □ smoking (syrup of Ipecac)
- □ protective sports gear
- □ seat belts/car seats
- □ stranger safety
- □ severe weather plans
- □ teaching your child
- □ sleeping
- □ smoke detectors
- □ toilet training
- □ fire escape plans
- □ storing cleaning supplies/medication
- □ toy/playlist
- □ protective sports gear

Do you have questions, concerns, or want information about:

- □ bike helmet/safety
- □ emergency/hotline
- □ family relations
- □ gun safety
- □ kindergarten
- □ carbon monoxide
- □ phone numbers
- □ fire escape plans
- □ protective sports gear
- □ lead poisoning
- □ other child rearing issues
- □ poisoning (syrup of Ipecac)
- □ protective sports gear
- □ seat belts/car seats
- □ stranger safety
- □ severe weather plans
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- □ toilet training
- □ fire escape plans
- □ storing cleaning supplies/medication
- □ toy/playlist
- □ protective sports gear

### Learning

Please check all boxes that describe your child:

- □ says numbers from 1 to 10
- □ stutters, stammers
- □ has trouble being understood
- □ understands other people
- □ points to or names the bigger of two objects
- □ understands “one”, gives you just one when asked
- □ knows how many fingers are on each hand
- □ compares things, for example, says “this one is bigger, heavier,” etc.
- □ counts three or more objects
- □ copies a circle or other shapes
- □ tells when one object is longer or shorter
- □ prints first name or part of it
- □ seems clumsy when using hands
- □ seems clumsy; stumbles, falls, walks or runs poorly
- □ seldom plays with other children
- □ clings or gets very upset when leaving you
- □ seems overly friendly
- □ seems timid, fearful, or worries a lot
- □ acts much younger than age
- □ seems unhappy, cries, whines
- □ has trouble paying attention
- □ seems overly aggressive
- □ has trouble sitting still
- □ plays in a variety of ways

Developed by the Minnesota Department of Education; Minnesota Department of Health; Minnesota Department of Human Services; and Dr. Harry Ireton, University of Minnesota.

MDE/Early Childhood Screening

08.17.06