

**Grace Presbyterian Child Care Center**  
**6671 Yale Rd. – Bartlett, TN 38134 – (901) 386-4689**  
**HEALTH HISTORY CHECKLIST**

\_\_\_\_\_

Child's Name

\_\_\_\_\_

Birth Date

\_\_\_\_\_

Parent Name

The answer to these questions will help us to know if your child has any medical problems. We need this information in case he/she would become ill and we would be unable to reach you right away. Please circle the correct answer.

**Pregnancy and Birth**

- Yes No 1) Were there any problems with pregnancy or your child's birth?  
Yes No 2) Was his/her birth weight under 5 1/2 pounds?  
Yes No 3) Did the baby have any problems in the hospital?

**Medical Problems**

- Yes No 4) Has your child ever been in the hospital overnight?  
Yes No 5) Is your child taking any medicine?  
Yes No 6) Any allergies or reactions to medicine, DTP, or other shots or insects?  
Yes No 7) Has your child had asthma or wheezing?  
Yes No 8) Does your child have speech or hearing problems?  
Yes No 9) Has your child had more than two ear infections in a year?  
Yes No 10) Has your child had tonsillitis?  
Yes No 11) Does your child have trouble with his eyes or seeing?  
Yes No 12) Has your child had a bladder or kidney infection?  
Yes No 13) Does he/she have burning when urinating?  
Yes No 14) Does he/she have seizures, fits or shaking spells?  
Yes No 15) Have you ever been told your child has a heart murmur?  
Yes No 16) Is your child able to play as hard as other children?  
Yes No 17) Has your child ever had a bumpy, swollen reaction to the TB skin test?  
Yes No 18) Has your child ever been with anyone having TB?  
Yes No 19) Has your child ever had worms?  
Yes No 20) Does your child scratch his/her genitals?  
Yes No 21) Is your child a hemophiliac (free bleeder)?  
Yes No 22) Is your child on a heart monitor?  
Yes No 23) Does your child have tubes in his/her ears?

**General Development**

- Yes No 26) Is your child in a special education class at school?  
Yes No 27) Does your child get along well with other children?  
Yes No 28) Is he/she usually happy?  
Yes No 29) Does your child have any special problems not indicated above? (Please note below)  
Yes No 30) When did your child last see a doctor (month/year): \_\_\_\_\_ / \_\_\_\_\_

**Additional Information**

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