

BBNA Head Start

PO Box 310 Dillingham, AK 99576
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HEALTH HISTORY

CHILDS NAME: _____ BIRTH DATE: ____ / ____ / ____ COMMUNITY: _____

FAMILY HISTORY	YES	NO	PLEASE EXPLAIN "YES" RESPONSES
ALLERGIES			
Does your child have any allergies? (please list)			
Any allergies to medicine? (what medicines)			
HOSPITALIZATION/SERIOUS ILLNESS			
Has child ever had surgery that required hospitalization?			
Has child suffered any of the following: (head injury, broken bones, burns, poisoning)?			Date(s):
Has child ever had a serious illness such as meningitis?			
HEALTH CONCERNS			
Does child have frequent: (please circle applicable responses) sore throat, cough, vomiting, diarrhea, constipation, stomach pain, urinary tract infections?			If yes, has child been treated?
Do you have specific concerns about your child's health or behavior at this time?			
Does child have ear trouble such as (please circle): frequent earaches or complaints of ear pain, ear discharge, rubs/pulls ear, tubes in ears?			
Has child ever had a convulsion or seizure? If yes, does child take prescribed medicine?			Medicine: Most recent seizure date:
Please list all medicines your child is taking currently :			
Does child have (please circle): asthma, seizures, respiratory problems, other _____?			Date:
Is your child exposed to second hand smoke?			Date:
ORAL HEALTH/DENTAL			
Does child appear to have trouble with teeth or gums?			
Has child ever received a dental exam?			Most recent exam date:
VISION			
Have you observed your child squinting, crossing eyes, or holding objects very close to his/her eyes?			
Has an eye doctor performed a vision exam on your child?			If yes, include date:
Does child wear glasses (or need to be wearing glasses) at this time?			Glasses worn since:
Has child had an exam with the Screening Camera?			Date:

Parent/Guardian signature: _____ **Date:** _____