Spokane Head Start/EHS
HEALTH, DENTAL AND DIET HISTORY

Date ____________________________ Site __________________ Room ________ ☐ a.m. ☐ p.m. ☐ full day

HEALTH HISTORY

Date of last well child exam ______/_____/______ Birth date ______/_____/______

Birth weight ______ pounds ______ ounces Month prenatal care started ________________________

Mother’s health during pregnancy ____________________________________________________________

Did your child have problems at birth? (i.e., jaundice, oxygen needed, didn’t cry, etc.) ____________________________

Please mark the following conditions that apply to your child with an “E” or “P” to indicate an Existing or Past condition.

☐ Allergic condition ☐ Bowel/bladder accidents ☐ HIV
☐ Respiratory (A) ☐ Cancer (M) ☐ Heart trouble (C)
☐ Drugs (W) ☐ Constipation/diarrhea/food intolerance (B) ☐ Neurological problems (N)
☐ Foods (F) ☐ Diabetes (D) ☐ Seizures with/without fever (S)
☐ Insects (I) ☐ Eczema/skin condition (K) ☐ Serious accidents/injuries
☐ Latex (J) ☐ Eating/swallowing difficulties (E) ☐ Surgery/hospitalization
☐ Pollens/dust ☐ Exposure to TB/respiratory disease (R) ☐ Urinary tract infections (U)
☐ Anemia/sickle cell/blood disease (B) ☐ Hearing implants/aides/ear problems (H) ☐ Vision: wears glasses or patch (V)
☐ Bone/orthopedic (O) ☐ Hepatitis C ☐ Other ____________________________

☐ Place an “X” here if any of the above conditions are LIFE THREATENING2 and designate which one ____________________________

Please explain items that are Existing ____________________________

1. Do you have any concerns about your child’s health? ☐ No ☐ Yes If yes, what? ____________________________
2. Does your child take any medicine (vitamins, prescription or over the counter) on a regular basis? ☐ No ☐ Yes If yes, what? ____________________________
3. Does your child have special needs or need help to participate in classroom activities (i.e., help with toileting, etc.)? ☐ No ☐ Yes If yes, what? ____________________________

DENTAL HISTORY

Date of last dental exam ______/_____/______ ☐ my child does not have a dentist

Has your child ever had any cavities? ☐ No ☐ Yes If yes, have they been fixed? ☐ No ☐ Yes

Does your child brush his/her teeth daily? ☐ No ☐ Yes

Do you help brush his/her gums/teeth? ☐ Always ☐ Sometimes ☐ Never

Does your child drink from a baby bottle or spill-proof cup at bedtime or naptime? ☐ No ☐ Yes If yes, content: ____________

Do you have concerns about your child’s teeth? ☐ No ☐ Yes If yes, explain ____________________________

Do you have family dental concerns? ☐ No ☐ Yes If yes, explain ____________________________

My child is currently enrolled in the ABCD dental program. ☐ No ☐ Yes

If not, I would like to enroll my child in the ABCD dental program. ☐ No ☐ Yes

I give my child systemic fluoride drops/tablets at home. ☐ No ☐ Yes

I choose not to give my child systemic fluoride. ☐ No ☐ Yes

Our family uses fluoride toothpaste, gels and/or mouthwash at home. ☐ No ☐ Yes

☐ My child is too young for fluoride drops or tablets (less than six months of age).

PLEASE COMPLETE THE OTHER SIDE

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1 Give Special Diet Letter to parents
2 Health specialist referral, when appropriate

CCS 98-116 (Rev. 04/18) (HS/HN) Marketing and Public Relations
### DIET HISTORY

#### EVERYONE

Does your family restrict any foods for religious, cultural, ethical or personal reasons?  
- [ ] No  
- [x] Yes***  
  If yes, what foods and why?  

Does your child have any chewing or swallowing problems?  
- [ ] No  
- [x] Yes*  
  If yes, explain  

Do you have any concerns about what your child eats or weighs?  
- [ ] No  
- [x] Yes***  
  If yes, explain  

Is your child currently on WIC?  
- [ ] No****  
- [x] Yes  
  If yes, which office?  

Does WIC have any concerns about your child’s growth or diet?  
- [ ] No  
- [x] Yes  
  If yes, what?  

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#### INFANT (breastmilk/formula; 0 to 4 months)

How do you feed your baby?  
- [ ] Breast  
- [ ] Bottle  
- [ ] Both  
  What do you put in the bottle?  

Formula type used:  
- [ ] Low iron**  
- [ ] With iron  

Quantity consumed at one feeding?  
Temperature of formula?  

How often is the bottle offered?  
Bottle type  
Nipple type  

Expresses hunger by  

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#### EXPLORER (introduction to solids; 4 to 12 months)

How do you feed your baby?  
- [ ] Breast  
- [ ] Bottle  
- [ ] Both  
  What do you put in the bottle?  

Foods my baby has been offered:  
- [ ] Cereal  
- [ ] Fruits  
- [ ] Vegetables  
- [ ] Meats  
- [ ] Other  

Expresses hunger by  
Type of cup used  

How would you rate your child’s appetite  
- [ ] Good  
- [x] Poor***  

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#### TODDLER (table foods; 8 to 36 months)

How do you feed your baby?  
- [ ] Breast  
- [ ] Bottle  
- [ ] Both  
  What do you put in the bottle?  

Foods my toddler has been offered:  
- [ ] Eggs  
- [ ] Poultry  
- [ ] Vegetables  
- [ ] Bread  
- [ ] Fruit  
- [ ] Dairy products or milk  
- [ ] Fish  
- [ ] Meat  
- [ ] Cereal  
- [ ] Rice  
- [ ] Juice  

How would you rate your child’s appetite  
- [ ] Good  
- [x] Poor***  

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#### PRESCHOOL (3 to 5 years)

How would you rate your child’s appetite  
- [ ] Good  
- [x] Poor***  

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Parent/guardian signature  
Date  

Updated form parent/guardian signature  
Date  

Updated form parent/guardian signature  
Date  

- [ ] Reviewed by ed. staff  
- [ ] Reviewed by FSC  
- [x] Reviewed by nurse consultant - Infants Only  

Date/initial  
Date/initial  
Date/initial  

* Nurse referral  
** Children who do not receive high-iron formula or milk require a letter from their health care provider  
*** Dietitian referral  
**** WIC referral