



# APOSTOLIC KIDDIE ACADEMY

5020 Pleasant Ridge Road

Knoxville, TN 37912

## CHILD'S HEALTH HISTORY CHECKLIST

...they shall mount up with wings as eagles...

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Child's Name

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Birthdate

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Parent/Guardian Name

The answers to the following questions will help us know if your child has any medical problems. We need this information in case he/she should become ill, and we would need to be able to reach you right away. Please circle the right 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 at the hospital?               |

### Medical Problems

- |     |    |   |
|-----|----|---|
| Yes | No | 4. Has your child ever been in the hospital overnight?                      |
| Yes | No | 5. Is your child taking medicine? (If yes, please list them at the bottom.) |
| 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 tonsilitis?  |
| Yes | No | 11. Does your child have trouble with his/her 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 genital area?                           |
| Yes | No | 21. Is your child 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 | 24. Is your child in a special education class in school?          |
| Yes | No | 25. Does your child get along well with other children?            |
| Yes | No | 26. Is he/she usually happy?                                       |
| Yes | No | 27. Does your child have any special problems not indicated above? |
| Yes | No | 28. When did your child last see a doctor?                         |

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Month

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Year

Medications your child is currently taking: \_\_\_\_\_