Date Form Completed ______________

EASTERN ILLINOIS AREA OF SPECIAL EDUCATION

5837 Park Drive, Suite 1
Charleston, IL 61920
Phone: 217/348-7700 Fax: 217/348-7704

MEDICAL HISTORY AND CURRENT HEALTH STATUS

Student Name			Birthdate	Sex	Age
Resident District	Attendance District		Building Name		Grade
Teacher(s)	Referred by				
Parents/Guardian	Address (City, State, Zip)			Home Phone -	
Employed at: (Father)	Phone	Employed at: (Mother)		Phone	

PRENATAL HISTORY

1. Did the mother have any health problems or accidents during the pregnancy?

____
____
____
____
____
____

2. Was the child full term? __________ If not, how premature? ______________

3. Any problems during labor or delivery? Length of Labor ______________

____
____
____
____
____
____

4. Child's condition at birth - Weight: __________ Color: ______________

Known health problems

____
____
____
____
____
____

5. Has this child ever been unconscious? ______________________

How long? ____________

6. Has this child ever had a convulsion or seizure?

____

CURRENT HEALTH INFORMATION

1. Does the child have any current health problems or do you have any concerns about the child's health?

____

____

____

____

____

2. Has the child had routine dental care? ______________________

3. Does this child have any of the following symptoms ***more frequently than others?***

- ☐ allergies, asthma, hayfever, sinus trouble
- ☐ ear infections
- ☐ colds, sore throats
- ☐ headaches, stomachaches
- ☐ general aches and pains
- ☐ sleep disturbances (walking or talking, nightmares, bed-wetting)
- ☐ overly active
- ☐ eye strain or difficulty seeing

4. Does the child's physical development appear age appropriate?

____

FAMILY MEDICAL INFORMATION

1. Does anyone in the family have a history of:

- ☐ Vision problems ______________________
- ☐ Hearing problems ______________________
- ☐ Speech problems ______________________
- ☐ Alcohol/drug problems ______________________
- ☐ Other medical problems ______________________

2. Who is the current physician for this child? ______________________

______________________ ______________________

(INFORMANT) (INTERVIEWER)

DEVELOPMENTAL HISTORY

1. Age sat alone? ______________
2. Age started to crawl? ______________
3. Age stood alone? ______________
4. Age walked unassisted? ______________
5. Age started using single words? ______________
6. Age spoke in sentences? ______________
7. Age toilet training accomplished? ______________

PAST HEALTH HISTORY

1. Any unusual or severe illnesses or accidents?

2. Any hospitalizations?

3. Has child been seen by any medical specialists?

4. Is your child currently taking any medications?

Has your child been on any medication for extended periods of time?