

Child's Name: _____

DOB: _____

Is the child in foster care? Yes No Social worker/Telephone _____

What language is spoken in the home? _____ Interpreter needed? Yes No

Back-up contact Name/Relationship _____ Phone _____

Is the parent active in the military service? Yes No Branch _____

Does the family live in military housing/base? Yes No Housing Dev./Base _____

INSURANCE INFORMATION

Medical Assistance Number (11 digits) _____ MCO _____

Private Insurance Carrier _____ Social Security Number _____

REM (Rare and Expensive Medical) Yes No

Model Waiver Yes No

SSI (Supplemental Security Income) Yes No

WIC (Women Infant Children) Yes No

REM Case Worker/Agency _____ Phone _____

CPS Social Worker _____ Phone _____

MEDICAL INFORMATION

Primary Care Provider _____ Phone _____

Hospital of Birth _____

Available Reports (check all that apply)

- Birth Discharge Summary
- Copy of Immunization Record
- Developmental Evaluation Report
- Audiology
- Vision
- Other _____

Services being provided (currently)

- Physical Therapy
- Occupational Therapy
- Speech & Language Therapy
- Nursing Services
- Special Instruction
- Other _____

COMMENTS:

Reminders:

1. Updated Immunization Record.
2. If over 30 months: copy of birth certificate, deed or lease.
3. Have copies of discharge summary and/or evaluation reports when Service Coordinator arrives for first home visit.

Child's name:

Date of birth:

**PRINCE GEORGE'S COUNTY INFANTS AND TODDLERS PROGRAM
HEALTH HISTORY**

PREGNANCY and BIRTH HISTORY

Was your child born prematurely (less than 38 wks)? yes no

If so, how early was your child born? _____ (weeks)

Were there any problems during pregnancy? yes no

Did you have a C-section? If so, why:

At which hospital was your baby born?

What was your baby's birth weight? (Pounds and ounces)

Were there any problems at or soon after birth? yes no

If YES, please check:

- | | | |
|--------------------------------------------|-----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Apnea monitor | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Oxygen needed | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Resistant to antibiotics |
| <input type="checkbox"/> Ventilator needed | <input type="checkbox"/> Tube feeding needed | <input type="checkbox"/> Other |
| <input type="checkbox"/> BPD | <input type="checkbox"/> NEC | |

Did he/she pass the newborn hearing screen? yes no not sure

Did he/she pass the newborn vision screen? yes no not sure

Were any follow-up hearing tests recommended? yes no not sure

Were any follow-up vision tests recommended? yes no not sure

How long was your baby in the hospital? Explain why if longer than 3 days.

Did he/she get transferred to any other hospital? yes no not sure

Child's name:

Date of birth:

CURRENT MEDICAL ISSUES

Are your child's immunizations up to date? yes no not sure
Has any medical provider informed you that your child has any health conditions? (such as asthma, sickle cell, metabolic or genetic problems) yes no not sure

Also, list specialists, location, and date last seen:

Does your child attend a NICU follow-up clinic or a developmental clinic?
yes no not sure

Has he/she been hospitalized since birth? If so, please explain why, which hospital, and dates.
yes no not sure

Has your child been tested for lead? yes no not sure
If YES, do you know the level?

Do you have any concerns about:

Your child's vision? yes no

Your child's hearing? yes no

A previous head injury? yes no

A lot of ear infections, IF YES yes no

How many ear infections? _____

Is your child taking any medications? yes no

DEVELOPMENTAL HISTORY

Have you ever noted anything unusual or slow about your child's development or behavior? yes no

Child's name:

Date of birth:

Do you remember the age when your child learned to:

MOTOR

Roll over _____ (mo)
Sit without support _____ (mo)
Pull to stand _____ (mo)
Walk alone _____ (mo)

LANGUAGE

Social smile _____ (mo)
Babble (dadada) _____ (mo)
Peek-a-boo* _____ (mo)
Single word _____ (mo)
Say 4-6 words _____ (mo)
Say 2 words together _____ (mo)

Current words: (attach word list as appropriate)

Any concerns that your child has lost any skills? yes no

If YES, describe at what age the loss of skills occurred: _____ (months)

FAMILY HISTORY

Who resides in the household?

Age (optional)

Is there any family history of the following conditions:

If YES, state relationship:

Mental retardation _____
Autism _____
Pervasive Developmental Disorder _____

Mental health problems _____
Seizures _____
Vision loss _____

Hearing loss _____
Speech/language problems _____
Learning problems _____

Key:
m=mother/f=father/s=sibling/a=aunt/u=uncle
c=cousin/g=grandparent/o=other

SOCIAL/RELATING (complete if child is 12 months and older)

Does your child take an interest in other children? yes no

Does your child ever use his/her index finger to point to indicate to someone else that something is interesting? yes no

Child's name:

Date of birth:

Does your child ever bring objects over to you to show you something? yes no

Does your child ever imitate you? (e.g. you make a face, will your child imitate it) yes no

Does your child respond to his name when you call? yes no

If you point at a toy across the room, does your child look at it? yes no

What is the child's daily routine like? Does he/she have the chance to be around peers?

Comments/Notes

Information obtained from: _____

Form completed by: _____

Date form completed: _____