7. At what age did he/she sit alone? .... ☐ Yes ☐ No
8. At what age did he/she walk alone? .... ☐ No ☐ Yes
9. Did your child say any words by the time he/she was 18 months old? .... ☐ No ☐ Yes
10. Does he/she have any trouble sleeping now? .... ☐ No ☐ Yes
11. Are there any concerns with his/her teeth? .... ☐ No ☐ Yes
12. Has your child had any serious accidents or broken bones? .... ☐ No ☐ Yes
13. Does he/she take daily medications? .... ☐ No ☐ Yes
    Which? ______________________
14. Other diseases or serious illnesses? .... ☐ No ☐ Yes
    List: ______________________
    ____
15. Any hospitalizations? For what? ______________________
    ____
16. Any operations? ______________________
    ____
17. Has he/she had chicken pox? .... ☐ No ☐ Yes

ALLERGIES:

1. Has your child ever had eczema or hives? .... ☐ No ☐ Yes
2. Has your child ever had wheezing or asthma? .... ☐ No ☐ Yes
3. Has he/she had any allergies or reactions to any medicines or injections? .... ☐ No ☐ Yes
   List: ______________________

PSYCHO-SOCIAL HISTORY:

1. Is your child doing well in school? .... ☐ Yes ☐ No
2. Does he/she get along with other children? .... ☐ Yes ☐ No
3. Does your child have any behavior problems that concern you? .... ☐ No ☐ Yes
4. Daycare? Sitter? .... ☐ No ☐ Yes

IMMUNIZATIONS:

1. How many "DPT" or diptheria, tetanus, and whooping cough shots has your child had? .... ________
   Date of last? ______________________
2. How many doses of polio vaccine by mouth (OPV)? .... ________
3. Has your child had the measles/mumps/rubella vaccine? .... ☐ Yes ☐ No
4. Has he/she had a skin test for TB? .... ☐ Yes ☐ No
   Last time? ______________________
5. Any other vaccines? List: ______________________

Parent / Guardian Signature: ____________ **Relationship:** ____________ **Date:** ________

ANY CHECKS IN THE RIGHT HAND COLUMN ARE INVESTIGATED:

____

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Reviewed by: ______________________

Signature **Title**