Toddler Developmental History

Child's Name_______________ Birth date___________ Today's Date_________

A. Health

1. Does your child seem well most of the time? Yes No

2. Is your child taking any medications now? (Including aspirin, laxatives, vitamins, etc.) Yes No

If yes, what?____________________ Why?______________________________

3. In a year, has your child had as many as 3 ear infections? Yes No

4. Are you concerned about your child's hearing? Yes No

5. In a year, does your child usually have more than 3 colds or sore throat infections with a fever? Yes No

6. Are you concerned about your child's eyes or vision? Yes No

7. Has your child been seen by a medical specialist? Yes No

If yes, who?____

Why?____

8. What arrangements have you made for the care of your child should he/she become ill at the center?_____________________________________

____

9. Does your child have any handicaps? Yes No

If yes, describe:

____

10. Other illnesses or diseases? Yes No

If yes, what?____

11. Does your child have any contagious illnesses that could impact other children or staff(malaria, Hepatitis A, Hepatitis B, HIV, AIDS, etc.)? Yes No

If yes, what?____

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12. Has your child been hospitalized? Yes No

If yes, describe: ____________________

13. Has your child had any serious accidents or poisonings?

Yes No

If yes, what? ____________________

14. Does your child chew unusual things such as pencils, chalk, cribs, window ledges, paint chips, plaster or hair? Yes No

If yes, describe ____________________

15. Has your child had any of the following? Please circle"

Premature Birth   Trouble breathing at birth

Birth injury or defect   Head Injury

Convulsions/ seizures

Allergies (eczema, hives, drug, food intolerance, hay fever, wheezing, asthma, insect stings)

Describe: ____________________

B. Developmental History:

At what age did your child begin to walk ____________________

How do you comfort your child? ____________________

What are your child's favorite toys? ____________________

What are your child's favorite activities? ____________________

What language(s) is spoken in your home? ____________________

Has your child bee in a group child care setting previously? __________

C. Sleeping:

Do you have any specific ways of helping your child go to sleep? _____

____

What is your child's current sleeping schedule?

Night time: from__________ to__________

AM naptime: from__________ to__________

PM naptime: from__________ to__________

Does your child use a sleeping toy at naptime? Yes No

Does your child use a blanket at naptime? Yes No

D. Feeding:

What is your child's present eating schedule? (specify amounts)

	Juices	Food	Milk/Formula
Breakfast	____________	____________	______________
Lunch	____________	____________	______________
Snack	____________	____________	______________

Does your child have any feeding problems? Yes No

If yes, what are they? ____

____

E. Toileting:

How frequently does your child have a bowel movement? ____________

Appearance of bowel movement(hard, soft). ________________________

Does your child frequently have diaper rash? Yes No

How is it treated? ____

Can we use our ointment if you have not provided it? _____________
Is your child toilet trained? Yes No

What word does your child use for urination? _____________________

For bowel movement? ____

Does he/she use a potty chair? Yes No

Can he/she easily manage the types of clothing worn?

Yes No