Niles Township District for Special Education
Initial Medical History Form

Today's Date_____
Child's Full Name_____ Age_____
Date of Birth ____/____/____ Place of Birth _____ Sex_____
Parent/Guardian_____
Pediatrician Information:
Name_____
Address_____ Phone Number_____

FAMILY HISTORY	Yes	No	RELATIONSHIP
Genetic Disorder	☐	☐	_____
Cognitive Impairment	☐	☐	_____
PDD/Autism	☐	☐	_____
ADHD	☐	☐	_____
Mental Illness	☐	☐	_____
Substance Abuse	☐	☐	_____

PREGNANCY / BIRTH INFORMATION
Mother's age at birth _____ number of pregnancies_____ number of siblings_____

		Yes	No
1.	Was your pregnancy considered "high risk"? If yes, why? _____	☐	☐
2.	Did child's mother receive routine prenatal care?	☐	☐
3.	Did mother have any illnesses, injuries or other complications during the pregnancy with this child? If yes, Please check which one(s): ☐ Infection: _____ ☐ High Blood Pressure ☐ Diabetes ☐ Ultrasound abnormality ☐ Injury/Accident: _____ ☐ Other: _____	☐	☐
4.	Did mother use any of the following during pregnancy? ☐ Alcohol ☐ Tobacco ☐ Drugs	☐	☐
5.	Was the baby born within 2 weeks of the due date? If no, early by_____ weeks late by_____ weeks	☐	☐
6.	Was the baby delivered vaginally? Were forceps used during the delivery? If delivered by a C- Section, what was the reason? _____	☐ ☐	☐ ☐
7.	What was the birth weight? _____ length?_____ Apgar Scores:_____		

		Yes	No
8.	Did the baby have any complications during the newborn hospital stay?	☐	☐

If yes, please check which one(s):
- ☐ Breathing problems
- ☐ Jaundice requiring treatment
- ☐ Infection
- ☐ Birth injury/trauma
- ☐ Birth defect
- ☐ Other: _____

9.	Did the baby require treatment during the hospital stay?	☐	☐

If yes, please check which one(s):
- ☐ Oxygen administration-length of treatment: _____
- ☐ Mechanical support for breathing-length of treatment: _____
- ☐ Blood Transfusion
- ☐ Other: _____

10. Length of hospital stay: _____

DEVELOPMENTAL HISTORY	Yes	No	AGE
Uses a cup	☐	☐	_____
Feed self	☐	☐	_____
With Fingers	☐	☐	_____
With Spoon/Fork	☐	☐	_____
Assists with dressing	☐	☐	_____
Dresses self	☐	☐	_____
Bladder control	☐	☐	_____
Bowel control	☐	☐	_____
Does your child talk?	☐	☐	
If yes, at what age did your child begin to talk?			_____
Does your child walk?	☐	☐	
If yes, at what age did your child begin to walk?			_____

Was there a regression in your child's developmental skills? ☐ Yes ☐ No

If yes, at what age did regression occur? _____

CHILD'S MEDICAL HISTORY

Has your child been diagnosed with a medical and/or neurological condition? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Diagnostic Testing:

Has your child received diagnostic testing? ☐ Yes ☐ No

If yes, please check which one(s):
- ☐ Genetic testing Results: _____
- ☐ Electroencephalogram (EEG)
- ☐ Electrocardiogram (EKG)
- ☐ CT scan
- ☐ MRI
- ☐ Other: _____

Medical Treatments:

Does the child require special medical treatments? ☐ Yes ☐ No

If yes, please check which one(s)?

- ☐ Gastrostomy tube feeding
- ☐ Catheterization
- ☐ Colostomy care
- ☐ Nebulizer Treatment
- ☐ Tracheotomy Care
- ☐ Other: _____

Hearing and Vision Screenings/Evaluations:

Has the child received a hearing screening? ☐ Yes ☐ No

Results: _____

Has the child had an audiogram or audiologic evaluation? ☐ Yes ☐ No

Results of evaluation: _____

Where did evaluation occur: _____

Date of evaluation: _____

Has the child received a vision screening? ☐ Yes ☐ No

Results: _____

Has the child's vision been examined by an optometrist/ophthalmologist? ☐ Yes ☐ No

Results of examination: _____

Were glasses prescribed? ☐ Yes ☐ No

Dental Examination:

Does your child receive routine dental care? ☐ Yes ☐ No

Date of last dental examination: _____

Medical Specialist Consulted:

Please list all specialist consulted (such as neurology, orthopedics, cardiology, endocrinology, psychology, ENT, and ophthalmology, dental):

Medical Specialty	Physician's Name	Date of visit

Additional medical information that would be helpful:

_____

_____

_____

_____

_____

Informant's Signature: _____ Relationship: _____ Date: _____

Previous Hospitalizations/Emergency Room Visits:

Age of Child	Reason for Hospitalization	Length of Stay

Previous Surgeries:

Age of Child	Surgery

Serious Medical Illnesses:

Does the child have any serious or long-term medical problems (such as asthma, seizures, diabetes, heart defect, frequent ear infection or developmental problems)? ☐ Yes ☐ No

Age of Child	Illness

Serious Medical Injuries:

Has the child had any major accidents/injuries (such as burns, lacerations, sprains, fractures or head injuries) that required medical attention? ☐ Yes ☐ No

Age of Child	Injury

Allergies: ☐ Yes ☐ No

If yes: To what?	Symptoms caused by allergy?	Treatment, if any

Diet:

Is your child on a special diet? ☐ Yes ☐ No

If yes, please list: _____

Does your child have any dietary restrictions or food sensitivities? ☐ Yes ☐ No

If yes, please list: _____

Medications:

Please list all medications including over the-counter-drugs taken on a daily basis and the reason for use:

_____

_____

_____

_____