Hartford HealthCare
St. Vincent's Special Needs Services

HEALTH HISTORY INTERVIEW

IDENTIFYING DATA Date: _____________

Student's Name: ______________________________________ Birth Date: ________________________

Present Address: ______________________________________ Telephone: ________________________

Birthplace: ____

Dominant Language: Verbal: __________Written: __________ Receptive: ___________ Non-verbal: __________

Other languages spoken at home: ________________________________

Primary Health Care Provider: ____

Address: ____ Telephone: ________________________________

Parent /Guardian Name: ____

Address: ____

Telephone: Home ________________ Work ______________ Cell _________________

Parent /Guardian Name: ____

Address: ____

Telephone: Home ________________ Work _______________ Cell ________________

A. FAMILY DATA

List family members and other persons living in the household.

NAME	SEX	AGE	RELATIONSHIP

B. LIST SCHOOL /PROGRAMS Attended

List all services received and/or programs attended chronologically:

NAME	CITY/STATE	DATES ATTENDED

C. LIST AGENCIES OR RESOURCES from which you receive support.

INTERVIEW DATA

Historian's Name: ______________________________________ Relationship to student: ___________________________

1. Description of student's difficulties/parental concerns:

____

____

2. Description of areas in which you desire help for your son/daughter:

____

____

3. How did you become aware of our program?

____

BIRTH HISTORY

BACKGROUND DATA (Check all that apply)

# of pregnancies________# of live births _________

This child is adopted _______ a foster child ______ a step child _______ multiple birth ________

A. PRENATAL HISTORY:

1. How would you describe your general health and well-being during pregnancy?

____

2. Did you have health supervision during your pregnancy? _____ Yes _____ No

   If yes, with whom? (Type of practitioner) __________________________________

   If yes, in what month did your supervision begin? ___________________________

3. Were ultrasounds or other tests done during pregnancy? _____Yes _____No

   If yes, which one (s) ____

   If yes, for what purpose? ____

4. Did you have any of the following problems during pregnancy? (check all that apply)

	MONTH(S)	DETAILS	CANNOT SAY
Bleeding			
Vomiting			
Rashes (diagnosis)			
Fever			
Diabetes			
Edema/swelling			
High blood pressure/toxemia			
Injury/accidents			

Infection			
Other			

B. LABOR AND DELIVERY HISTORY

1. How many weeks long was your pregnancy? __________ (weeks of gestation)

   Were you treated for pre-term labor? ______Yes ______No If yes, explain: _________________________

2. Was labor induced? ______Yes ______No

   If yes, please give details: ____

3. How long was the labor? _______ Hours (total)

4. Did you have anesthesia for delivery? ______Yes ______No

   If yes, explain: ____

5. What type of delivery did you have: ______vaginal ______forceps ______vacuum extraction _____C-section

   If C-section, explain: ______________________________________

6. Were there any complications with labor and delivery (i.e. cord around the neck)

   ____

5. Birth weight: ______lb./kg Birth length ______in/cm Apgar's: ______1 min. ______5 min.

6. Were there any of the following difficulties after delivery? (check all that apply):

   ___ Birth defects ___Transfusion ___Problem sucking

   ___ Difficulty breathing ___Injury ___Gagging/vomiting

   ___ Needed oxygen ___Surgery ___ Diarrhea

   ___ Resuscitation ___ Fever ___ Jitteriness

   ___ RH problem ___ Infection ___ Seizures

   ___ Jaundice/use of lights ___ Medications ___ Other

   Details (description, treatment):

   ____

   ____

7. Did your baby spend time in a newborn special/intensive care unit after delivery?

   _______ Yes _______No If yes, for how long? ____

   Details:____

DEVELOPMENTAL HISTORY

INFANCY/EARLY CHILDHOOD BEHAVIORS

1. How would you describe your baby during the first year?

   Feeding: ____

   Sleeping: ________________________________ Temperament: _______________________________________

2. Were there any concerns about your child during the first 3 years? ______Yes ______No

   If yes, give details: ____

CURRENT FUNCTIONING

1. What toys does your child play with at home?

   ____

   ____

2. What is your child's sleep pattern?

   ____

   ____

3. Describe your child's eating habits. Any difficulties?

   ____

   ____

TUBERCULOSIS EXPOSURE

1. Was your child born outside the US? _____ yes _____ no

   If yes, where? ____

2. Has your child traveled outside the US? _____ yes _____ no

   If yes, where? ____

   How long? ____

   With whom did the child stay? __________________________

3. Has your child been exposed to anyone with TB disease? _____ yes _____ no

4. Does your child have close contact with someone with a positive tuberculosis-screening test?

   _____ yes _____ no

5. Does your child spend time with anyone who has been in jail, prison or a shelter, injects illegal drugs, or has HIV?

   _____ yes _____ no

6. Has your child drunk raw milk or eaten unpasteurized cheese since the last tuberculin skin test?

   _____ yes _____ no

7. Does your child have a household member who was born outside the US? _____ yes _____ no

   If yes, from what country? ____

   Does your child have a household member who has traveled outside the US for greater than one month?

   If yes, where? ____ _____ yes _____ no

HEALTH HISTORY

HEALTH MAINTENANCE DATA

1. Has your child been seen by his/her primary health care provider in the last year for a physical exam?

   ______Yes ______No

2. Has your child been seen by his/her Specialist health care provider for illness in the past year? ___Yes ___No
3. Current Diagnosis(is)____

   ____

   ____

4. List Type of disability and severity: ____

   ____

   ____

5. When was diagnosis made? Age of child at that time: ____________________________
6. Treatment and/or interventions with dates: ____

   ____

   ____

C. RECORD OF HEALTH PROBLEMS (Give details on next page)

TYPE OF HEALTH PROBLEM (check all that apply)	**Never**	**Un-sure**	**0-6 mos**	**7-12 mos**	**13-18 mos**	**19-24 mos**	**2 yrs**	**3 yrs**	**4 yrs**	**5-7 yrs**	**8-11 yrs**	**12-15 yrs**	**15-21 yrs**
Skin problem/rash													
Headache													
Fever over 103 ◦													
Loss of consciousness													
Meningitis													
Seizures/convulsions/spells													
Tic/tremor													
Trouble with eyes													
Ear infection													
Hearing													
Cleft lip/palate													
Apneic spells/breath holding													
Bronchiolitis/bronchitis													
Pneumonia													
Allergies													
a. environmental													
b. food													
c. drug													
Asthma													
Cardiac													

TYPE OF HEALTH PROBLEM (check all that apply)	Never	Un-sure	0-6 mos	7-12 mos	13-18 mos	19-24 mos	2 yrs	3 yrs	4 yrs	5-7 yrs	8-11 yrs	12-15 yrs	15-21 yrs
Gastrointestinal													
Diarrhea (chronic)													
Colic/abdominal pain													
Constipation (chronic)													
Diabetes													
Genitourinary problems/ deformity													
Growth													
Over/under activity													
Thyroid													
Under/overweight													
Weight loss/gain (acute)													
Anemia (“low blood count”)													
Blood transfusion													
Cancer/leukemia													
Lead poisoning													
Other poisoning/ injury													
Serious injury/accident													
Fracture													
Hospitalization													
Surgery													
Other serious condition													

HEALTH PROBLEM DETAILS

____

____

____

____

List all diagnostic tests/procedures (EEG, MRI, Ct Scan, Xray, Modified Barium Swallow, etc.)

TYPE	DATE	RESULT

List all HOSPITALIZATIONS:

Date	Reason

D. **REVIEW OF SYSTEMS** (Items below refer to the last 12 months only)

Skin:

______ Change in color ___ Scars
______ Change in texture ___ Altered pigmentation (i.e. café au lait spots, vitiligo)
______ Rash
Specifics: ____

Hair:

______ Alopecia (hair loss) ______ Excessive growth of fine body hair
______ Change in texture
Specifics: ____

Head/Face:

______ Pain ______ Shunt ______ Asymmetry
______ Atypical faces ______ Concussion/Injury
Specifics: ____

Eyes:

______ Squinting ______ Ptosis (drooping eye lid) ______ Tearing
______ Pruritus (itch) ______ Strabismus (crossed eyed) ______ Blinking
______ Nystagmus (oscillating eye movement) ______________ Other
______ Glasses prescribed
Specifics: ____
LAST vision exam: ______________________________Results: ____________________________

Ears/Nose/Throat:

______ Hearing problem ______ Frequent otitis media ______ Polyps
______ Sores/herpes ______ Chronic otitis media ______ Excessive wax
______ Mouth breathing/snoring ______ Frequent URI ______ PE tubes
______ Constant nasal drainage ______________________ Other
______ Recurrent infections _____ ear _____ nose _____ throat _____ sinus
Specifics: ____

LAST hearing exam: __________________________ Results: _________________________________

Mouth:

Condition (teeth and gums): _______________________ Cavities: ____________________________
Speech problems: ____

Chest/Breast:

______ Pain ______ Masses/cysts ______ Discharge
______ Nipple abnormalities ______ Infection ______ Gynecomastia
______ Pectus carinature (pigeon chest) ______ Pectus excavatum (funnel chest)
Specifics: ____

Cardiac:

Murmur: ______ functional ______ pathological ______ High Blood Pressure
______ Shortness of breath ______ Squatting ______ Cyanosis
______ Congestive heart failure ______ Clubbing of fingers/toes
______ Congenital defect
Specifics: ____

Respiratory:

______ Wheezing ______ Shortness of breath ______ Bronchiolitis
______ Persistent cough ______ Pneumonia ______ Asthma
______ Sleep Apnea
Specifics: ____

Gastrointestinal:

______ Nausea/vomiting/gagging ______ Abnormal stool ______ Diarrhea
______ Incontinence ______ Parasites ______ Pica (eating non-food items)
______ Abdominal pain ______ Constipation ______Hepatitis type ___

Urinary:

______ Dysuria (difficulty/pain) ______ Pyuria (pus in urine) ______ Dribbling
______ Polyuria (excessive) ______ Enuresis (incontinence)
______ Frequency/urgency ______ Blood in urine
______ Frequent infection ______ lower back pain
Specifics: ____

Genital tract:

Male: ______ Discharge/infection/lesion ______ Abnormal genitalia
Female: ______ Discharge/infection/lesions ______ Abnormal genitalia ____ menstruation occurred
Specifics: ____

Musculoskeletal:

______ Muscle atrophy ______ Contractures
______ Weakness/paralysis ______ Postural deformity (scoliosis)
Specifics: ____

Neurological:

______ Hyper/hypotonia ______ Poor coordination ______ Unusual gait
______ Seizures ______ Staring episodes ______ Poor strength
______ Altered pain/temperature sensation ______ Syncope (fainting) ______ Other
Specifics: ____

Endocrine:

______ Over or under activity ______ Accelerated or delayed growth
______ Altered sweating mechanism ______ Abnormal thyroid growth
______ difficulty tolerating heat
Specifics: ____

Hematopoitic:

______ Sickle Cell disease/Trait ______ Anemia ______ Petechiae
______ Thalassemia disease/Trait ______ Lengthy bleeding ______ Bloody nose
______ Hemophilia ______ Easy bruising
Specifics: ____

1. Medications: Please list all medications/vitamins/fluoride/over-the-counter drugs used:

NAME	REASON	DOSAGE/TIMES

2. Adaptive equipment

Please list ALL adaptive equipment or devices that your child uses:

____

____

____

Are there any current equipment needs? ____

FAMILY HISTORY

Are there any significant developmental or significant health conditions in the student's siblings, parents or grandparents health history? Y______ N______

SOCIAL DATA

1. Have there been any significant family losses or changes in your family household in the last year? ___ Yes ___ No

   If yes please explain: ____

2. Religion____