HEALTH HISTORY &
NUTRITION ASSESSMENT
NESD HEAD START

Child Name________________________________
Ctr/HB____________________________________
Interviewer________________________________
Date______________________________________

Does your child:	**YES**	**NO**
1. Have any medicine or environmental allergies? List:	____	____
2. Take any medications? List:	____	____
3. Have any current medical problems? List:	____	____
4. Have any past surgeries? List:	____	____
5. Have exposure to 2nd or 3rd hand smoke? 2nd=Smoke / 3rd=Clothes, furniture, etc.	____	____

Does your child:	**YES**	**NO**
1. Have a food intolerance or allergy? List:	____	____
2. Require a special diet? List:	____	____
3. Have trouble chewing or swallowing? Explain:	____	____
4. Do you have any concerns about what Your child eats? Explain:	____	____

Health Coordinator________ Date_______ Health/Nutrition Manager________Date_______

2/2013