Jardim de Infancia D. José da Costa Nunes

ANAMNESIS

IDENTIFICATION

Name:

Date of Birth: Sex: F ☐ M ☐

Nationality:

FAMILY HISTORY:

Number of Siblings: ___________ Ages: ____________

Family Composition: Mother's Age: ______ Father's Age: ___________

The children lives with: ____

PREGNANCY AND DELIVERY

Was a planned pregnancy? ________________Gestation Period: _________________________

Any medication during the pregnancy? No ☐ Yes ☐ Wich? ______________

Types of Labor: Normal ☐ C- section ☐ Other:___________________

Weight: Any Complication after Birth?

During the first 3 months? Any Seizure: __________ Suction: Normal ☐ No: _______

CHILD MEDICAL HISTORY

Any Chronic disease: No ☐ Yes ☐

Which one? ___________________

Any Hospitalizations: ____

Any Surgeries: No ☐ Yes ____

Takes regular medication: (Excluding occasional medication for fever or flu)

Yes ____

Allergies: No ☐ Yes? ____

Normal Bowel Function?

Child have any physical difficulty:

Locomotion difficulty:

Sensorial (For exemple hearing or vision):

Does the child need any special medical attention?

FAMILY MEDICAL HISTORY

Any disease? (Chronic diseases or hereditary disease in the family including the grandparents)

DEVELOPMENT:

Which age did your child start to walk?

When did your child start eating by himself?

Does your child undress by himself?

Does he need any help to dress?

When did your child stop using diaper? Please specify the age.

At daytime: At daytime and night time:

Does your child need any help to use the toilet?

Does your child brush his teeth by himself / herself?

When did your child start saying words?

SLEEPING AND FEEDING:

With whom is your child sleeping with?

Parents ☐ Siblings ☐ Alone ☐ Others:

What time does your child goes to bed and what time does he wake up?

Does your child have any routine before sleep? If yes, please specify.

Does your child use pacifier or any other object to fall a sleep?

Does your child wakes up due to nightmares?

Is your child afraid of some particulars things or situations? If yes, please specify.

Did you have any problem changing from liquid to solid food?

Does your child have any difficulty at meal time? If yes, please specify.

Does your child feed himself? If no, please put an X on the person who use to feed your child:

Mother ☐ Father ☐ Siblings ☐

Other family relation ☐ Helper ☐

Does your child have breakfast at home?

What does he/she eat?

Milk ☐ Bread ☐ Cereals ☐ Others:

Your child daily diet includes:

Rice ☐ Pasta ☐ Soup ☐ Vegetables ☐ Salad ☐

Meat ☐ Fish ☐ Eggs ☐ Dairy products ☐ Fruit ☐

Sweets ☐ Others:

What is your child favorite food?

FAMILY RELATION:

With whom does your child relates more?

Mother ☐ Father ☐ Sibling ☐ Helper ☐ Grandfather ☐ Grandmother ☐

What is your child favorite games/toys?

Outgoing with parents?

Where does your child usually goes to?

Park ☐ Museum ☐ Swimming pool ☐ Other:

What is your child's favorite place?

OTHER OBSERVATION

Guardian signature:

____

Date:___/___/___