**EC 5B**

**EAST CENTRAL SPECIAL EDUCATION**

**Developmental History**

Student’s Name:   

 (Last) (First) (Middle)

Grade: 

School: 

Parent/Guardian:  Date: Click here to enter a date.

Length of Pregnancy: 

Any Pregnancy Complications:



Any Birth Complications:



Birth Weight: 

Age Began Crawling: 

Age Began Walking: 

Age Began Talking: 

Age Toilet Trained:

Day: 

 Night: 

Activity Level:

 [ ] Less Active than Average

 [ ] Average

 [ ] More Active than Average

Surgery? Yes[ ]  No[ ]

Explain:



Head Injury? Yes[ ]  No[ ]

Explain:



Broken Bones? Yes[ ]  No[ ]

Explain:



Hospitalizations:

Overall Health: Good[ ]

Fair[ ]

Poor[ ]

Glasses: Yes[ ]  No[ ]

When were eyes last checked? Click here to enter a date.

Has Hearing Ever Been Checked? Yes[ ]  No[ ]

History of Ear Infections? Yes[ ]  No[ ]

Tonsils Removed? Yes[ ]  No[ ]

Adenoids Removed? Yes[ ]  No[ ]

Tubes in Ears? Yes[ ]  No[ ]

Allergies? Yes[ ]  No[ ]

List Allergies:



Asthma? Yes[ ]  No[ ]

Medication (Type & Dosage):



Bed Wetting? Yes[ ]  No[ ]  Sometimes[ ]

 How Often? 

Any Sleep Difficulties:



Any Eating Difficulties:

