**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:

