PRESCHOOL/KINDERGARTEN MEDICAL HISTORY QUESTIONNAIRE

Child's Name:_____ Siblings(How Many): _____ Number Older _____Number Younger_____

Birthdate_____ Medical Insurance: ____Private ____Medicaid/Title 19 ____ Hawk I ____ None (Please check)

Date:_____ Dental Insurance: ____Private ____Medicaid/Title 10 ____ Hawk I ____ None (Please check)

Physician_____ Date of last exam _____ Hospital Preference_____ Dentist_____Date of last exam_____

Parent(s)_____ Child lives with ____ Both Parents ____ Mother ____ Father _____ Other(Who?) _____

Age of Mother at birth_____ Age of Father at birth_____ Parents married? ____ Yes ____No

Highest level of education of parents at birth of child: Mother _____ Father_____

Child's birthweight_____ Was your child premature? ___ Yes ___No If yes, gestational age at birth_____

Is your child unusually shy, quiet, or sensitive? If yes, please explain_____

Does your child cry easily, become overactive, or have temper tantrums? If yes, please explain_____

Please check yes, no, or don't know for the following questions and give explanations where asked.

	YES	NO	DON'T KNOW	
Did your child attend Preschool/Daycare?	____	____	____	Name of Preschool/Daycare_____
Has your child had any eye problems?	____	____	____	Please explain_____
Has your child had an eye/vision exam?	____	____	____	Doctor/Date_____
Does your child wear eye glasses?	____	____	____	For close up or far away?_____
Has your child had ear problems?	____	____	____	Please explain_____
Has your child had tubes placed in ears?	____	____	____	When and are they still in place_____
Has your child had any teeth problems?	____	____	____	Please explain_____

OVER→

	YES	NO	DON'T KNOW	
Does your child have any speech problems?	____	____	____	Please explain_____
Does your child receive speech services?	____	____	____	Please explain_____
Has your child had any heart problem?	____	____	____	Please explain_____
Has your child had any heart surgery?	____	____	____	Surgery/Date_____
Has your child ever had seizures?	____	____	____	Date of last seizure_____
Is your child on seizure medication?	____	____	____	Name of medication_____
Does your child have asthma?	____	____	____	Type of asthma_____
Does your child take asthma medication?	____	____	____	Will he/she need at school_____
Does your child have any eating problems?	____	____	____	Please explain_____
Does your child have any allergies?	____	____	____	List allergies_____
Does your child take allergy medication?	____	____	____	List medications_____
Please list your child's allergy symptoms (cough, rash, wheeze, etc)_____				
Your child have any bladder/bowel problems?	____	____	____	Please explain_____
Does your child toilet independently?	____	____	____	Please explain_____
Does your child have any other health concerns?	____	____	____	Please explain_____
Has your child had any serious injuries?	____	____	____	Please explain_____
Any past/future surgeries?	____	____	____	Please explain_____
Has your child had the chickenpox?	____	____	____	Month/year of illness_____
Does your child have any orthopedic concerns?	____	____	____	Please explain_____
Has Keystone evaluated your child?	____	____	____	Please explain_____

***I agree that this information can be released to school personnel who need to know.**

Parent Signature_____ **Date**_____