

Child's Name _____ Birthdate _____

Parent's Name _____ Address _____

A. Pregnancy & Birth

1. Did mother have any illness or rash during pregnancy with this child? Yes No
If yes, specify illness and month of pregnancy _____
2. During this pregnancy, did mother have any symptoms such as: Yes No
High blood pressure Yes No Vaginal bleeding Yes No
Swelling of legs Yes No Seizures Yes No
3. Did the baby come at the expected time of delivery? Yes No
4. Did the mother have difficulty during labor and/or delivery? Yes No
5. What was the birth weight?..... _____ lbs. _____ oz.
6. Did the baby have any trouble while in the hospital? Yes No
7. Did the baby have any trouble starting to breathe? Yes No
8. Did the baby go home with the mother? Yes No
9. Was this pregnancy planned? Yes No

B. Health

1. Does this child feel well most of the time? Yes No
2. In a year, has this child had as many as three episodes of ear trouble?..... Yes No
3. In a year, does this child usually have more than three colds or sore throat infections with a fever? Yes No
4. Has this child had any allergies or reaction to any medicines or injections? Yes No
5. Does this child complain frequently of headache, leg ache, stomach ache, or other pain? (circle)..... Yes No
6. Has this child had trouble with his/her eyes or vision?..... Yes No
7. Is this child's appetite usually good? Yes No
8. Do any foods disagree with this child?..... Yes No
9. Does this child have any difficulty sleeping?..... Yes No
10. Does this child have any problems with his/her teeth?..... Yes No
11. Does this child chew unusual things such as pencils, cribs, window ledges, paint chips, plaster, or hair? Yes No
If yes, please specify _____
12. Is this child taking any medicine now? (for example: aspirin, laxatives, etc.?) Yes No
If yes, please specify _____
13. Does this child have trouble getting rid of severe cough?..... Yes No

B. Health

14. Circle any of the following diseases this child has had: "Red" or "Hard" Measles, German or 3-day Measles, Mumps, Meningitis, Pneumonia, Chickenpox, Scarlet Fever, Strep Infections, High Fever (above 104° for extended period of time)..... Yes No
15. Has this child ever been exposed or had contact with a person with tuberculosis? Yes No
16. Has this child ever had or does this child have: (please circle)
- | | |
|---------------------|-----------------------------|
| Constant cold | Trouble urinating |
| Wheezing or asthma | Kidney or bladder infection |
| Eczema or hives | Bowel troubles |
| Swollen glands | Convulsions or fits |
| Heart trouble | Difficulty hearing |
| Rheumatic fever | Diabetes |
| Shortness of breath | |
17. Does this child have a good urinary stream? Yes No
18. Other illnesses or diseases? if yes, what? Yes No
19. Has this child ever been hospitalized? If yes, for what? Yes No
20. Has this child had any serious accidents? If yes, what? Yes No
21. Does this child have any physical restrictions? If yes, what? Yes No
22. Has this child ever been seen by a medical specialist? If yes, who? Yes No

C. Growth & Development

1. At what age did this child sit alone? yrs. mos.
2. At what age did this child walk alone? yrs. mos.
3. Did this child say any words by the time he/she was 1-1/2 years old? Yes No
4. At what age did this child use sentences? yrs. mos.
5. Does this child ask questions beginning with what, how, where, when, who? Yes No
6. Does this child ever say he/she feels sad, bad, mad, happy, glad? Yes No
7. How does this child treat or get along with:
- FATHER? _____
- MOTHER? _____
- BROTHERS? _____
- SISTERS? _____
- OTHER CHILDREN? _____
8. Has this child had any school experience such as Sunday School, Nursery School, Head Start, Dancing, Gymnastics, etc.? Yes No
9. What things does this child like to do for fun? _____
- _____
10. What activities does this child do particularly well? _____
- _____
11. With what household tasks does this child help? _____
- _____
12. What new things have you noticed this child doing within the last six months? _____
- _____

C. Growth & Development

13. Is there anything additional that you would like to tell us about your child? _____

D. As part of our pre-school medical examination, we need information about your child's behavior, development, emotions, moods, or physical or psychological factors that might influence his/her response to school life and requirements.

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|--|------------------------------|-----------------------------|------------------------------------|
| 1. Is your child more active than average? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 2. Is your child quiet and less active than average?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 3. Does your child tire easily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 4. Does your child still wet the bed at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 5. Does your child have any problems with speech? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 6. Does your child seem to have trouble hearing you?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 7. Does your child wake up earlier than the rest of the family? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 8. Is your child awkward, clumsy, or poorly coordinated? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 9. Does your child seem slow to you in any way?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 10. Does your child still need a nap? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 11. Does your child frequently misunderstand what you tell or ask him? . | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 12. Do others pick on him/her a lot?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 13. Is your child upset when separated from his mother?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 14. Does your child have a lot of trouble with his brothers or sisters?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 15. Do you think he/she is unusually selfish?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 16. Do you fear that your child may be too babyish or immature?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 17. Is your child timid with other children?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 18. Is your child easily frustrated and irritable? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 19. Does your child get angry easily and often?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 20. Do you think your child is overly sensitive? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 21. Does your child prefer to play alone or with much younger children?. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 22. Does your child cry easily? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 23. Do you think your child is nervous, high strung, or excitable? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 24. Does your child want to be the center of attention all the time?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 25. Does your child have nightmares or frightening dreams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 26. Does your child wake at night often? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 27. Does your child give up on things if he/she cannot do them well? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 28. Do you think of him/her as shy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 29. Is our child quite stubborn?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 30. Does your child soil his/her underclothes sometimes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 31. Does your child seem unusually fearless or reckless?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 32. Does your child bite his/her fingernails? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 33. Does your child put off things like going to bed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 34. Is he/she a finicky eater? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |
| 35. Does your child dawdle over breakfast or getting dressed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes |

36. What is his/her greatest fear? _____
37. What is your greatest concern about your child? _____
38. Do you anticipate any problems in school? Yes No Sometimes
39. Are there any problems at home or in the neighborhood that might trouble him/her or have effect on his/her emotions or behavior?..... Yes No Sometimes
40. Are there any problems or characteristics of behavior, emotions, or development that you have wanted to talk over with a doctor? Yes No Sometimes
- Are there any of these that are troubling you now?..... Yes No
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E. Food Intake Record

- I. 1. Does your child eat one or more of the following foods every day? oranges, orange juice, grapefruit juice, cantaloupe, fresh strawberries, broccoli, brussel sprouts? Yes No
2. Does your child eat one or more of these following foods three times a week or more? carrots, pumpkin, sweet potato, spinach, winter squash, apricots, cantaloupe, tomatoes or tomato juice? Yes No
3. Does your child eat two or more servings of any combination of the following foods every day? potato, cabbage, cauliflower, watermelon, lettuce, plums, peaches, grapes, bananas, apples, green or wax beans, corn, peas, asparagus, or additional servings of the fruits and vegetables listed in questions 1 & 2 above?. Yes No
- II. 1. Does your child drink milk fortified with vitamins A and B? Yes No
2. How much milk does your child drink in a 24-hour period?
- a. Less than 2 cups (16 ounces) each day? Yes No
- b. 2-4 cups (16-32 ounces) each day? Yes No
- c. More than 4 cups each day?..... Yes No
3. Does your child eat other foods made with milk every day? cheese, pudding, yogurt, cream soups, ice cream Yes No
- III. 1. Does your child eat one or more servings of the following foods every day?
- a. Meat, fish, poultry? Yes No
- b. Lunch meat, hot dogs, baked beans, split peas?..... Yes No
- c. Peanut butter (2 tablespoons)? Yes No
- d. Liver or liver sausage (Braunschweiger)? Yes No
- e. Eggs?..... Yes No
- IV. 1. Does your child eat four or more servings every day from the following foods? Whole grain or enriched bread, rolls, crackers, cereals (cooked or ready-to-eat), waffles, pancakes, macaroni, noodles Yes No
2. What brand of cereal does your child generally eat? _____
- V. 1. Does your child eat three or more servings of the following foods every day? pre-sweetened cereals, candy, cake, doughnuts, pie, cookies, pop, Kool-Aid, fruit drinks (Tang, Hawaiian Punch, Hi-C, etc.), jelly, honey, potato chips, popcorn, corn chips?..... Yes No
2. Does your child take vitamins regularly? Yes No
- If yes, do they contain iron? Yes No