

Health History – Preschool/School Age

(To be completed by parent before admission) (Fax back to American Montessori at 952-736-8430)

Child's Name: _____ Age: _____ Birth Date: _____

Section A: Health History

1. Does this child seem **well** most of the time? Yes No
2. In a year, has this child has 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. Does this child have trouble getting rid of **severe coughs**? Yes No
5. Does this child complain frequently of **headache, leg ache, stomach ache or other pain**? Yes No
6. Has this child had trouble with his/her **eyes or vision**? Yes No
7. Is child's **appetite** usually good? Yes No
8. Does this child **chew unusual things** such as pencils, cribs, window ledges, paint chips, plaster or hair (Pica)? Yes No
9. Does this child have any trouble **sleeping**? Yes No
10. When was he/she last seen by a **dentist**? (Date: _____), (If over six months, check **NO**) Yes No
11. Was all the **dental work** he/she suggested completed? Yes No
12. Was this child seen by a **doctor** since last clinic exam? Yes No
If yes, when? _____ What for? _____
13. Is this child taking any **medicines** now (for example: Aspirin, Laxatives, etc.)? Yes No
If yes, what medications? _____ What for? _____
14. **Past History** – Circle any of the following conditions this child has ever had:

<ul style="list-style-type: none"> • “Red” or “Hard” Measles • German or 13 day measles • Mumps • Physical handicap • Convulsions, Seizure, fits • Heart Trouble • Allergies (Eczema, hives, drug or food intolerance, hay fever, wheezing, asthma) 	<ul style="list-style-type: none"> • Kidney or bladder infection • Diabetes • Pneumonia • Meningitis • Scarlet Fever • High Fever (Above 104 for 3 days or more) 	<ul style="list-style-type: none"> • Birth injury or defect • Head Injury • Chickenpox • Premature Birth • Trouble Breathing at birth
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15. **Recent History** - Circle any of the following this child has had recently:

<ul style="list-style-type: none"> • Frequent Urination • Small stream or dribbling • Burning or Painful Urination • Constant Cold 	<ul style="list-style-type: none"> • Bowel Problems • Dizziness, fainting spells • Tires Easily • Swollen Glands 	<ul style="list-style-type: none"> • Shortness of Breath • Difficulty Hearing • Bleeds Easily • Joint Pain
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16. Other **illness or disease**? Yes No
If yes, what? _____
17. Has this child **been hospitalized**? Yes No
If yes, for what? _____
18. Has this child had any **serious accidents or ingestions**? Yes No
If yes, list type, when and how treated? _____
19. Does this child have any **physical restrictions**? Yes No
If yes, what? _____
20. Has this child ever been seen by a medical specialist? Yes No
If yes, who and why? _____
21. Has this child ever had a **sickle cell test**? (If yes, when? _____) Yes No

Section B: Growth and Development History

1. Does child get along well with?
- | | | |
|----------------|------------------------------|-----------------------------|
| Mother | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Father | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Brothers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sisters | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other Children | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: _____

2. Are you concerned about your child in any of the following areas?
- | | | |
|---|------------------------------|-----------------------------|
| a. Bedwetting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Wetting during the day | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Difficulty going to bed or staying in bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Bad dreams, wakefulness, disturbed sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Biting nails, nervous habits | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Thumb sucking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Stammering or stuttering | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Irritability, easily upset, feelings hurt easily | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Restlessness, over activity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Daydreaming, mind not on what he/she is doing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Overly cautious, fearful, shy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Wanting too much attention, comfort or support, clinging | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Breath Holding | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| n. Contrary, stubborn, uncooperative, disobedient | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| o. Selfishness, inability to share | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| p. Jealousy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| q. Anger, temper tantrums | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| r. Destroying things on purpose | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| s. Clumsiness, awkwardness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| t. Too much concern about sex for age | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: _____

3. What experience has this child had with groups (Day Care, Preschool, Head Start, church or temple school)? _____

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

Parents Signature: _____

Date Signed: _____