# KinderActivity Pre-School
# Health History Form

Date ___________________

Name of Child: _______________________________________________________

Birth date: __________________________________________________________

Gender (please circle): M / F

Date of Last Physical Exam: ______________________________________________

Does your child have? Please check.

___ Frequent colds
___ Frequent sore throats
___ Frequent ear infections
___ Frequent with skin rash
___ Heart trouble
___ Convulsions
___ Fainting spells
___ Diabetes
___ Asthma
___ Allergies types: _______
___ Stomach Upsets
___ Urinary Problems
___ Problems with diarrhea
___ Problems with constipation

Has your child had any of these diseases? Please check and date.

___ Bronchitis Date _______
___ Ringworm _______
___ Impetigo _______
___ Ringworm _______
___ Head lice _______
___ Chicken pox _______
___ Hepatitis _______
___ Scarlet fever _______
___ Tuberculosis _______
___ Measles (Hard) _______
___ German measles _______
___ Mumps _______
___ Poliomyelitis _______
___ Whooping cough _______
___ Worms _______

Has your child had illness other than those listed above? (If yes please explain)

Has your child ever been hospitalized? (If yes, please explain)

Has your child had injuries with fratures or loss of consciousness? (If yes, please explain)

When was your child's vision and hearing last tested? (By whom?)

When did your child last visit the dentist?

Has any other member of your family been seriously ill recently?

Is there a family history of asthma? Allergies? Epilepsy? Diabetes?