



HEALTH QUESTIONNAIRE—KINDERGARTEN
(To be completed by parent(s))

Patient Name: _____ Date _____

Parent(s) Name: _____

School _____

- | | | |
|---|-----|----|
| 1. Has your child had serious injuries or illness? | Yes | No |
| 2. Does your child have any symptoms of hay fever or asthma? | Yes | No |
| 3. Has any close relative had heart problems before 55 years of age? | Yes | No |
| 4. Has your child ever been in a hospital for surgery or any other reason? | Yes | No |
| 5. Are there significant illnesses that run in the family? | Yes | No |
| 6. Has your child or anyone they live with ever had tuberculosis or a positive TB skin test? | Yes | No |
| 7. Is your child able to sit and work at a project for a half hour or so? | Yes | No |
| 8. Do you feel your child's vision and hearing are OK? | Yes | No |
| 9. Are your child's eyes straight? | Yes | No |
| 10. Has your child had chicken pox or the immunization? | Yes | No |
| 11. Do you have any worries about your child's health or other questions you would like to discuss with your physician? | Yes | No |

If questions 1 thru 6 are answered with a "yes", please give a short description of the problem in the space below with appropriate dates.

PLEASE NOTE:

Well health care visits are important to check on growth and development, nutrition, and to provide guidance for your child. There may be time when you have a significant health concern or behavioral concern or a problem that we identify during your child's health check that will need to be addressed at a separate office visit in order to provide ample time for this concern.

Have your child write their name here _____