MULTICARE ASSOCIATES
MEDICAL CENTERS

Blaine Medical Center
11855 Ulysses St. NE, Blaine, MN 55434
Fridley Medical Center
480 Osborne Road NE, Fridley, MN 55432
Roseville Medical Center
1835 County Rd C-West, Roseville, MN 55113

763-785-4500

KINDERGARTEN HEALTH HISTORY

Date_____

You have made an appointment for a complete Kindergarten physical on_____ with _____. Please check in at _____ .

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 the illness and month of pregnancy_____
2. During this pregnancy, did mother have any symptoms such as:
   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? ☐ NO ☐ YES
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? ☐ NO ☐ YES
9. Was this pregnancy planned? ☐ NO ☐ YES

B. HEALTH

1. Does this child feel well most of the time? ☐ NO ☐ YES
2. In a year, has this child had as many as 3 episodes of ear trouble? ☐ YES ☐ NO
3. In a year, does this child usually have more than 3 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? ☐ NO ☐ YES
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
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
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)

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	Heart Trouble	Difficulty hearing
Wheezing or asthma	Kidney or Bladder infection	Rheumatic Fever	Diabetes
Eczema or hives	Bowel troubles	Shortness of breath	Swollen glands
Convulsions or fits			

17. Does this child have a good urinary stream? . . . . . ☐ NO ☐ YES

18. Other illnesses or diseases? . . . . . ☐ YES ☐ NO
    If yes, what? _____

19. Has this child ever been hospitalized? . . . . . ☐ YES ☐ NO
    If yes, for what? _____

20. Has this child had any serious accidents? . . . . . ☐ YES ☐ NO
    If yes, what? _____

21. Does this child have any physical restrictions? If yes, what? . . . . . ☐ YES ☐ NO
    If yes, what? _____

22. Has this child ever been seen by a medical specialist? . . . . . ☐ YES ☐ NO
    If yes, who7 _____

C. GROWTH & DEVELOPMENT

1. At what age did this child sit alone? YRS_____ MO_____
2. At what age did this child walk alone? YRS_____ MO_____
3. Did this child say any words by the time he/she was 1-1/2 years old? . . . . . ☐ NO ☐ YES
4. At what age did this child use sentences YRS_____ MO_____
5. Does this child ask questions beginning with what, how, where, when, who? . . . . . ☐ NO ☐ YES
6. Does this child ever say he/she feels sad, bad, mad, happy, glad? . . . . . ☐ NO ☐ YES
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? . . . . . ☐ NO ☐ YES
   If yes, does he do as well as the other children in his/her class? . . . . . ☐ NO ☐ YES
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? _____

    _____

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 response to school life and requirements.

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

36. What is his 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 or have effect on his 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

_____

_____

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 Potatoes, 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?
Potatoes, 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 & 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 4 or more servings every day from the following foods?
Whole grain or enriched bread, rolls, crackers, cereal (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