



West Amwell Township Elementary School

1417 Route 179 ★ Lambertville, New Jersey 08530-3413

Dr. Todd A. Fay, Superintendent ★ Mrs. Mitzi Morillo, Principal

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www.westamwellschool.org

Child's Name: _____ Birth date: _____

This questionnaire will help the doctor and school nurse to find out if your child is in the best of health for school. The questionnaire will become part of your child's personal health record and is of course confidential. If you plan to have your family doctor administer the examination, take the questionnaire with you when your child is examined, as your answers will help in the process.

1. Please write down any special questions you have regarding your child's health.
2. The doctor or school nurse will help you with any questions you might have with parts of the questionnaire

3. Please circle the correct answer:

Has your child had headaches or dizzy spells?	No	Yes
Convulsions or other seizures?	No	Yes
Trouble with speech?	No	Yes
Trouble with his/her eyes or with sight?	No	Yes
Nose bleeds, constant colds, frequent sore throat or sinus?	No	Yes
Frequent ear infections or trouble hearing?	No	Yes
Asthma, wheezing, cough, bronchitis, pneumonia?	No	Yes
Heart trouble or rheumatic fever?	No	Yes
Frequent vomiting or diarrhea?	No	Yes
Tendency to bleed easily?	No	Yes
Kidney or bladder infection?	No	Yes
Eczema or hives?	No	Yes
Mumps, measles, rubella, chickenpox or whooping cough?	No	Yes
Any serious sicknesses at any age?	No	Yes
Special doctoring at any age?	No	Yes
Any operations?	No	Yes
Any bad accidents or broken bones?	No	Yes
Allergies, hay fever or asthma?	No	Yes
Tiring easily, loss of vigor, or trouble fighting off infections?	No	Yes
Any trouble sleeping or nightmares?	No	Yes
Thumb sucking, nail biting, stammering, stuttering?	No	Yes
Nervous habits, high strung, easily upset, temper tantrums?	No	Yes
Shy, glum, sulky, or feelings easily hurt?	No	Yes
Wanting too much attention, disobedient?	No	Yes

4. Please answer these questions about the history of pregnancy, birth and early life.

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|---|----|-----|
| Was there sickness or complications during pregnancy? | No | Yes |
| Did you have any infections or viruses? | No | Yes |
| Was there high blood pressure or extra water? | No | Yes |
| Did you take any medicine in pregnancy? | No | Yes |
| Did the pregnancy go the full time? | No | Yes |
| Was there trouble with the labor and delivery? | No | Yes |
| Was the baby abnormal at birth or was there a birth defect? | No | Yes |
| Was there difficulty soon after birth? | No | Yes |
| Was there any problem with colic, crying, vomiting, sleeping, or settling the baby? | No | Yes |

Birth weight _____ Walked alone _____ months Said a few words _____ months

Family Physician _____ Date of last check-up _____

Times seen by doctor in last year _____

If any questions have been answered yes, please give more information, dates, ages, of each condition when possible.
