

Notes on filling out this form:
Please fill in or mark with a cross

MEDICAL HISTORY QUESTIONNAIRE

Child's family name	Child's first name	Born on	Nationality	Number of other siblings
Native language (Mother/Father)	Native language(Father/Mother)	Number of adults in the household	Has been attending a crèche/daycare/kindergarten for <input style="width:50px;" type="text"/> years	
Name and address of parent or legal guardian				
Family name First name..... Place of residence/postcode.....				
Street, house number..... Phone.....				
Pregnancy and birth				
Birth weight: _ _ _ _ grs. Completed pregnancy weeks: _ _ PWs <input type="checkbox"/> Multiple birth				
Development				
Has any delayed development <u>ever</u> been determined in your child? <input type="checkbox"/>Yes <input type="checkbox"/>No				
Speech disorder during development <input type="checkbox"/>Yes <input type="checkbox"/>No	Unassisted walking by 18 months <input type="checkbox"/>Yes <input type="checkbox"/>No			
First words (such as <i>mum, dad, car</i>) by 18 months <input type="checkbox"/>Yes <input type="checkbox"/>No	Child grows up multilingual <input type="checkbox"/>Yes <input type="checkbox"/>No			
In contact with the German language <input type="checkbox"/> from birth <input type="checkbox"/> not from birth				
If not in contact with the German language from birth, from which age? _ years _ _ months				
Is your child <input type="checkbox"/> right-handed <input type="checkbox"/> left-handed <input type="checkbox"/> still undecided				
Does your child have or has your child had one of the following illnesses or health impairments?				
Visual impairment <input type="checkbox"/> Yes <input type="checkbox"/> No Strabismus treatment <input type="checkbox"/> Yes <input type="checkbox"/> No Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No				
Does your child suffer from severe hearing impairment? <input type="checkbox"/>Yes <input type="checkbox"/> No				
If Yes, please answer the following questions:				
<input type="checkbox"/> Severe congenital hearing impairment <input type="checkbox"/> left ear <input type="checkbox"/> right ear				
<input type="checkbox"/> Acquired chronic hearing impairment <input type="checkbox"/> left ear <input type="checkbox"/> right ear				
<input type="checkbox"/> Wears hearing aid since left earMonth/year right earMonth/year				
<input type="checkbox"/> Wears cochlear implant since left earMonth/year right earMonth/year				
Rare congenital metabolic or hormone disorders: <input type="checkbox"/> No <input type="checkbox"/> Yes (which?) :				
<input type="checkbox"/> MCAD deficiency <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> PKU <input type="checkbox"/> CAH <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Diab. mell. (type 1) <input type="checkbox"/> Diab. mell. (type 2)				
Other chronic illnesses: <input type="checkbox"/>No <input type="checkbox"/> Yes (which?)				
Severe handicap: <input type="checkbox"/>No <input type="checkbox"/> Yes (which?)				
Must take the following medication regularly: <input type="checkbox"/>No <input type="checkbox"/> Yes (which?)				
Are you aware of illnesses your child may have that require specific procedures in emergency situations (e.g., allergies, epilepsy, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes				
If Yes, which?				
Has your child ever had any of the following assistance measures or treatments?				
Participation in German prep classes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Planned	
Speech therapy (logopedics)	<input type="checkbox"/> No	<input type="checkbox"/> Completed	<input type="checkbox"/> Ongoing	<input type="checkbox"/> Planned
Remedial education/orthopaedagogy/ergotherapy	<input type="checkbox"/> No	<input type="checkbox"/> Completed	<input type="checkbox"/> Ongoing	<input type="checkbox"/> Planned
Physiotherapy	<input type="checkbox"/> No	<input type="checkbox"/> Completed	<input type="checkbox"/> Ongoing	<input type="checkbox"/> Planned
Family doctor/pediatrician:				

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Place, Date

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Parent's or legal guardian's signature