

Is child on medication for any of the above? \_\_\_\_\_

e) Does your child attend speech classes? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please indicate where \_\_\_\_\_

f) Injuries or Accidents:

Types \_\_\_\_\_

AGE \_\_\_\_\_

g) Surgery:

TYPES \_\_\_\_\_

AGE \_\_\_\_\_

h) Last time child was seen by an eye doctor \_\_\_\_\_

i) Dental History

Condition of Teeth \_\_\_\_\_

Last time seen by dentist \_\_\_\_\_

j) Does your child take medication regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Medication \_\_\_\_\_ how frequently \_\_\_\_\_

Physician who prescribed medication \_\_\_\_\_

Medication was prescribed for what reason or reasons? \_\_\_\_\_

k) Other children in family: Number of Boys \_\_\_\_\_ Number of Girls \_\_\_\_\_

Anything else you may want to add: \_\_\_\_\_