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 ☐ years

Name and address of parent or legal guardian

Family name , First name ..... *Family name , First name* .....

Phone ..... *Phone* .....

Address .....

Pregnancy and birth

Birth weight: I__I__I__I__I *grs.* Completed pregnancy weeks: I__I__I *PWs* ☐ Multiple birth

Development

Has any delayed development ever been determined in your child? ☐Yes ☐No

Speech disorder during development	☐Yes ☐No	Unassisted walking by 18 months	☐Yes ☐No
First words (such as *mum*, *dad*, *car*) by 18 months	☐Yes ☐No	Child grows up multilingual	☐Yes ☐No

In contact with the German language ☐ from birth ☐ not from birth

If not in contact with the German language from birth, from which age? I__I years I__I__I months

Is your child ☐ right-handed ☐ left-handed ☐ still undecided

Does your child have or has your child had one of the following illnesses or health impairments?

Visual impairment ☐ No ☐ Yes Strabismus treatment ☐ No ☐ Yes Glasses ☐ No ☐ Yes

Does your child suffer from severe hearing impairment? ☐ No ☐ Yes

If *Yes*, please answer the following questions:

☐ Severe congenital hearing impairment ☐ left ear ☐ right ear

☐ Acquired chronic hearing impairment ☐ left ear ☐ right ear

☐ Wears hearing aid since left ear …… *Month/year* right ear …… *Month/year*

☐ Wears cochlear implant since left ear …….. *Month/year* right ear ……..… *Month/year*

Rare congenital metabolic or hormone disorders: ☐No ☐ Yes *(which?) :*

☐ MCAD deficiency ☐ Hypothyroidism ☐ PKU ☐ CAH ☐ Cystic fibrosis ☐ Diab. mell. (type 1)

Other chronic illnesses: ☐No ☐ Yes *(which?)* ……

Severe handicap: ☐No ☐ Yes *(which?)* ……

Must take the following medication regularly: ☐No ☐ Yes *(which?)* ……

Are you aware of illnesses your child may have that require specific procedures in emergency situations (e.g., allergies, epilepsy, etc.)? ☐ No ☐ Yes

If Yes, which? ……

Has your child ever had any of the following assistance measures or treatments?

Participation in German prep classes	☐ No	☐ Yes		☐ Planned
Speech therapy (logopedics)	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Remedial education/orthopaedagogy/ergotherapy	☐ No	☐ Completed	☐ Ongoing	☐ Planned
Physiotherapy	☐ No	☐ Completed	☐ Ongoing	☐ Planned

Family doctor/pediatrician: ……

…… ……

Place, Date Parent's or legal guardian's signature