

Pediatric Health History

Please complete this questionnaire and return it with your application. This information will only be used to help ALL Kids better serve your child(ren) and to evaluate the success of the program.



If you have more than four children, please make a copy of the form so that you can complete a health history for all the children for whom you are applying.

No child will be denied insurance because of a pre-existing condition.

Medical History

Check any of the following that apply to your child: (CHILD'S NAME)

Weighted less than 5 1/2 pounds at birth?				
Has a regular doctor?				
Had a complete medical checkup in the last 12 months?				
Been to the emergency room in the last 12 months?				
Up-to-date on immunizations?				
Had an eye exam in the last two years?				
Had a dental checkup in the last 12 months?				

Medical Conditions

Check any of the following conditions that your child has or has had:

Asthma				
Diabetes				
Birth Injury				
Epilepsy/Seizure Disorder				
Juvenile Rheumatoid Arthritis				
Spina Bifida				
Cleft Lip and/or Cleft Palate				
Heart Problem				
Hemophilia				
Cystic Fibrosis				
Hearing Loss				
Head Injury				
Spinal Cord Injury				
ADD or ADHD				
Mental health or substance abuse issues				
Treatment for mental health or substance abuse issues				
List any serious medical conditions not listed above:				

ALL Kids may not provide any additional special services for these conditions.

If you checked any of the above and would like to have more information for your child from ALL Kids partnering agencies, sign below.

By signing below, I agree for ALL Kids to share my child's information with ALL Kids health partners so that I may be contacted or receive written information about special services that may be available for my child's condition.

Parent's Signature _____ Date _____

Where did you hear about ALL Kids? Check all that apply:

- | | | | | |
|-----------------------------------|------------------------------------|-----------------------------------|--|---|
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Library | <input type="checkbox"/> Hospital | <input type="checkbox"/> Beauty/Barber Shop |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Magazine | <input type="checkbox"/> Work | <input type="checkbox"/> Health Fairs | <input type="checkbox"/> Sports Event |
| <input type="checkbox"/> Relative | <input type="checkbox"/> School | <input type="checkbox"/> Internet | <input type="checkbox"/> Health Department | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> T.V. | <input type="checkbox"/> Radio | <input type="checkbox"/> Mail | <input type="checkbox"/> Church/Synagogue | |

REMEMBER: PUT THIS QUESTIONNAIRE IN THE ENVELOPE WITH THE APPLICATION.