

HEALTH HISTORY

Child's physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical examination \_\_\_\_\_ Results \_\_\_\_\_

	Yes	No		Yes	No
Is child under care of physician now _____	<input type="checkbox"/>	<input type="checkbox"/>	Does child have good physical coordination _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Is child receiving any medication or drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Are there any emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
_____			_____		
Is there any excessive bleeding when cut _____	<input type="checkbox"/>	<input type="checkbox"/>	Summary (for doctor's use) _____		
_____			_____		
Has child ever been hospitalized _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Has child ever had surgery _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Is there any allergy to penicillin or other drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		
Are there other allergies: food - pollen - animals - dust - other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		

Has child any history of or difficulty with any of the following:

- |   |  |                                       |  |   |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Chronic sinus | <input type="checkbox"/> Hearing      | <input type="checkbox"/> Mastoid         | <input type="checkbox"/> Thyroid          |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Convulsions   | <input type="checkbox"/> Heart        | <input type="checkbox"/> Measles         | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Bladder        | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Mononucleosis   | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver        | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Other            |
| <input type="checkbox"/> Chicken pox    | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic fever |   |

Summary: (for doctor's use)

[Empty box for summary]

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

May we request release of your child's medical records for our reference \_\_\_\_\_ **Yes No**

This information was discussed with and given by \_\_\_\_\_

Relation to child \_\_\_\_\_