

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)

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 _____