Name:_____ Nickname:_____

Date of Birth:_____ Today's Date:_____

Parents' Names:_____

Child's Medical History: Please circle.

AIDS/HIV	Cerebral palsy	Hepatitis	Pneumonia	Thyroid Disease
ADD/ADHD	Chicken pox	Hernia	Polio	Ulcers/Heartburn
Allergies	Diabetes	Herpes	Psychiatric care	Other:_____
Anemia	Depression	High cholesterol	Rheumatic Fever	_____
Asthma	High blood pressure	Kidney Disease	Seizures	_____
Bleeding Disorder	Heart disease	Liver Disease	Stroke	_____
Bronchitis	Heart murmur	Migraines		_____
Cancer				

What medical problems run in the family? Please circle.

Alcoholism	Cancer	High blood pressure	Psychiatric Care
Arthritis	Diabetes	Kidney Disease	Stroke
Asthma	Heart Disease	Liver Disease	Thyroid Disease
Bleeding disorder	High cholesterol	Migraine	Other:_____

What surgeries has the child had?_____

Has the child ever been hospitalized?_____ What for?_____

Birth History: Where was the child born? _____ Birth Weight _____ Birth Length_____

Prematurity? _____ Jaundice? _____ Discharged home w/ mom?_____

Caesarian or vaginal delivery? _____ Complications?_____

Any pregnancy complications?_____

Immunizations up to date?_____

Who lives at home with the child?_____

Does he/she attend daycare or preschool? _____

Who is the main caregiver?_____

What grade is she/he in?_____

Are there any pets at home?_____

Do you have city or well water?_____

Does anyone smoke at home?_____

What **medicines** does he/she take?_____

_____

Is she/he **allergic** to any medicines or foods?_____

History taken by: _____