Medical History

1. Child's name _____ Date of Birth_____
2. Date of last Physical Examination _____

Does your child have any problems with any of these? (*please circle*)

Constipation
Convulsions
Diarrhea
Fainting Spells
Frequent Colds
Frequent Ear Infections Hepatitis Frequent Sore Throats
Lice
Ringworm
Skin Rash
Soiling
Stomach Upsets
Urinary Problem
Worms

Has your child had any of these? (*please circle*)

Asthma
Bronchitis
Chicken Pox
Diabetes
Heart Disease
Impetigo
Measles
Mumps
German Measles
Polio
Scarlet Fever
Tuberculosis
Whooping Cough

3. If you circled anything above please explain:

_____

_____

_____

_____

4. Other illnesses? (*apart from those listed above*)

_____

_____

5. Has your child been hospitalized? (*explain*)

_____

_____

6. Has your child had injuries with fractures or loss of consciousness? (*explain*)

_____

_____

_____

7. Last Vision Test Date _____Last Hearing Test Date _____
8. Last Dental Visit Date _____
9. Any other members of your family with serious illness recently?

_____

_____

_____

10. Any other members of your family history of: ASTHMA ____DIABETES ____ EPILEPSY____
11. Food or other allergies? (Please describe reactions and treatment for each allergy)

_____

_____

_____

_____