

**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"/> Other            |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Liver        | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Venereal Disease |
| <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 \_\_\_\_\_