MEDICAL HISTORY
(*To be filled out by parent*)

Child's Name: _____ Age: _____ Date of Birth: _____

Childhood Information:

Pregnancy and Childbirth. List any problems while carrying your child (*illnesses, medication, emotional trauma*) and the type of birth:_____

_____

_____

Development. List anything unusual (*early or late*) in your child's development (*walking, weaning, talking, eating, etc*.):_____

_____

_____

Medical History. List any serious illnesses, hospitalizations, accidents, injuries, or operations your child has had. Please list dates:_____

_____

_____

Does your child have or have they experienced the following? *(check all that apply):*

	Dizziness or Fainting Spells		Constipation or Diarrhea
	Frequent or Migraine Headaches		Pain or Bleeding During Bowel Movements
	Skin Allergies or Rashes		Unexplained Weight Change
	Warts or Sores		Rheumatism
	Chest Pain of Shortness of Breath		A Rupture or Hernia
	Spitting or Coughing up Blood		Pain in Back, Neck or Joints
	Sweating at Night		Difficulty walking, running or lifting
	Stomach aches or Indigestion		Heart trouble or disease
	Urinary Bleeding, Frequent Urination		Diabetes or Sugar in the Urine
	Arthritis		Goiter or Thyroid Disease
	High Blood Pressure		Venereal Disease
	Excessive Bleeding		Tumor, Growth, Cyst or Cancer
	Hemophilia		A Knee of Ankle Injury
	An Ulcer		Rheumatic Fever
	A Back Injury or Deformity		Anemia

	Scarlet Fever		Pneumonia
	Seizure, Convulsions or Epilepsy		Appendicitis
	Kidney Disorder		Ear Infection
	Frequent Colds		Mumps
	Chicken Pox		Polio
	Typhoid		Measles
	For Females Only:		Painful Menstruation
	Heavy Periods		Periods Longer than eight days
	Pregnancy		Abortion/Miscarriage

Childhood Illnesses. Check if child has had:

1. Chicken pox Age:_____
2. Measles Age:_____
3. Mumps Age:_____
4. German Measles Age:_____
5. Other Age:_____

Does you child have any physical limitations? _____ If yes, explain_____

_____

Allergies: Is your child allergic to any drugs, food, plants, etc.?

If so, please list:_____

Is your child on any prescription or over the counter medication at this time? Give reason and dosage.

_____

_____

Family History. Has your father, mother, sister, brother, or children had any of the following:

Diabetes_____ Depression _____

Tuberculosis_____ High Blood Pressure _____

Heart Disease_____ Emotional Disorders _____

List any fractures your child has had and age they occurred:

_____

_____

Child's Personal Information:

Height_____ Weight_____

Hair Color_____ Eye Color_____

Glasses /Contacts?_____

Corrective Shoes?_____

Hearing Difficulty?_____

Speech Impairment?_____

Braces (orthodontic)?_____

Give dates of the following:

Last Physical Exam_____

Last Dental Exam_____

Last Vision Exam_____

Please attach a copy of your child's insurance/medical card and any written prescriptions