

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

Is child under care of physician now _____ **Yes** **No**

Is child receiving any medication or drugs _____

Is there any excessive bleeding when cut _____

Has child ever been hospitalized _____

Has child ever had surgery _____

Is there any allergy to penicillin or other drugs _____

Are there other allergies: food - pollen - animals - dust - other _____

Does child have good physical coordination _____ **Yes** **No**

Are there any emotional problems _____

Summary (for doctor's use) _____

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"/> Veneral 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 _____