HEALTH HISTORY

Child's physician ______________________ Address ______________________ Phone ____________

Date of last physical examination ______________________ Results ______________________

	Yes	No
Is child under care of physician now ____________	☐	☐
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	☐	☐

	Yes	No
Does child have good physical coordination ____________	☐	☐
Are there any emotional problems ____________	☐	☐

Summary (for doctor's use) ______________________

Has child any history of or difficulty with any of the following:

______ Anemia	______ Chronic sinus	______ Hearing	______ Mastoid	______ Thyroid
______ Asthma	______ Convulsions	______ Heart	______ Measles	______ Tuberculosis
______ Bladder	______ Diabetes	______ Kidney	______ Mononucleosis	______ Veneral disease
______ Cerebral Palsy	______ Epilepsy	______ Liver	______ Mumps	______ Other
______ Chicken pox	______ Fainting	______ Malignancies	______ 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.

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	Yes	No
May we request release of your child's medical records for our reference ____________	☐	☐

This information was discussed with and given by ______________________

Relation to child ______________________