

CHILD MEDICAL HISTORY

Child's Name \_\_\_\_\_ Date \_\_\_\_\_
First Middle Last
Name of child's physician \_\_\_\_\_ Address \_\_\_\_\_
Date of child's last health examination \_\_\_\_\_ For what \_\_\_\_\_

Findings at that time \_\_\_\_\_

What is child's height \_\_\_\_\_ weight \_\_\_\_\_ Is child under medical care . . . . Yes \_\_\_ No \_\_\_
Is child in good health Yes \_\_\_ No \_\_\_ Is child taking any medications . . Yes \_\_\_ No \_\_\_
Is child pregnant (females) Yes \_\_\_ No \_\_\_ Has child ever been hospitalized. . Yes \_\_\_ No \_\_\_

Has child ever had:
A.I.D.S. . . . . Yes \_\_\_ No \_\_\_
Anemia . . . . . Yes \_\_\_ No \_\_\_
Asthma or Hay Fever. . . . Yes \_\_\_ No \_\_\_
Bone disorder. . . . . Yes \_\_\_ No \_\_\_
Cancer . . . . . Yes \_\_\_ No \_\_\_
Diabetes . . . . . Yes \_\_\_ No \_\_\_
Epilepsy or Convulsions. . Yes \_\_\_ No \_\_\_
Endocrine disorder . . . . Yes \_\_\_ No \_\_\_
Genital herpes . . . . . Yes \_\_\_ No \_\_\_
Gonorrhea. . . . . Yes \_\_\_ No \_\_\_
Heart murmur . . . . . Yes \_\_\_ No \_\_\_
Hepatitis. . . . . Yes \_\_\_ No \_\_\_
Kidney disorders . . . . . Yes \_\_\_ No \_\_\_
Liver disorders. . . . . Yes \_\_\_ No \_\_\_
Mental disorders . . . . . Yes \_\_\_ No \_\_\_
Nervous disorders. . . . . Yes \_\_\_ No \_\_\_
Oral herpes (cold sores) . Yes \_\_\_ No \_\_\_
Pneumonia. . . . . Yes \_\_\_ No \_\_\_
Rheumatic fever. . . . . Yes \_\_\_ No \_\_\_
Syphilis . . . . . Yes \_\_\_ No \_\_\_
Thyroid disorders. . . . . Yes \_\_\_ No \_\_\_
Tuberculosis . . . . . Yes \_\_\_ No \_\_\_

Is child prone to:
Colds . . . . . Yes \_\_\_ No \_\_\_
Sore throats. . . . . Yes \_\_\_ No \_\_\_
Ear infections. . . . . Yes \_\_\_ No \_\_\_
Is child allergic to:
Penicillin. . . . . Yes \_\_\_ No \_\_\_
Local anesthetics . . . . . Yes \_\_\_ No \_\_\_
Other (medications, dust, etc.) . Yes \_\_\_ No \_\_\_

Has child ever had:
Abnormal blood pressure(high,low) Yes \_\_\_ No \_\_\_
Abnormal heart conditions . . . . Yes \_\_\_ No \_\_\_
Adenoids removed(at what age \_\_\_) Yes \_\_\_ No \_\_\_
Tonsils removed(at what age \_\_\_). Yes \_\_\_ No \_\_\_
Any operations. . . . . Yes \_\_\_ No \_\_\_
Behavioral problems . . . . . Yes \_\_\_ No \_\_\_
Broken bones. . . . . Yes \_\_\_ No \_\_\_
Difficulty breathing. . . . . Yes \_\_\_ No \_\_\_
Fainting or Dizziness . . . . . Yes \_\_\_ No \_\_\_
Nausea or Vomiting. . . . . Yes \_\_\_ No \_\_\_
Prolonged bleeding from a cut . . Yes \_\_\_ No \_\_\_
Recent gain or loss in weight . . Yes \_\_\_ No \_\_\_
Other conditions or illnesses . . Yes \_\_\_ No \_\_\_

IF YES TO ANY OF THE ABOVE, please give details (dates, names, reasons, prescribing doctor, etc.) \_\_\_\_\_

Has child reached puberty. . Yes \_\_\_ No \_\_\_ Has child had a recent growth spurt Yes \_\_\_ No \_\_\_
Males - has voice changed. . Yes \_\_\_ No \_\_\_ Females - has menstration begun . . Yes \_\_\_ No \_\_\_
If yes to above - at what age \_\_\_\_\_
Is child adopted . . . . . Yes \_\_\_ No \_\_\_ Is child from another marriage. . . Yes \_\_\_ No \_\_\_