Child's Health History

(To Be Completed by Parent/Guardian or Medical Staff)

Child's Name ____

Has your child had any of the following conditions?

Disease History	Date
Whooping Cough	
Rubella	
Chicken Pox	
Mumps	
Measles	
Convulsions	
Diabetes	
Epilepsy	
Otitis Media	
Pneumonia	
Hernia	
Scarlet Fever	
Diphtheria	
Poliomyelitis	

Has your child had any surgeries?

Operations	Date
Tonsillectomy	
Adenoidectomy	
Appendectomy	
Mastoidectomy	
Tubes in Ears	
Other	

Dietary Restrictions? ____________

____

Food Allergies?

____

____

Other Allergies? ____

Is your child allergic to any ointments/lotions? ______________________________

Parent Concerns: ____

____

Existing illness:	Previous serious illness/injuries:
Hospitalization during past 12 months:	Any disabilities:

Any medication prescribed for long-term continuous use?

____

______________________________ ______________________________

Signature of Parent/Guardian Date

School-age Child: I certify that my child's immunization record is on file at the elementary school he/she attends.

______________________________ ______________________________

Signature of Parent/Guardian Date

The answer to these questions will help us know if your child has any medical problems. We need this information in case he/she should become ill and we are unable to reach you right away. **Please circle the appropriate answer.**

Pregnancy and Birth

Yes No 1. Were there any problems with pregnancy or birth?

Yes No 2. Was his/her birth weight under 5 ½ pounds?

Yes No 3. Was he/she premature?

Yes No 4. Did the baby have any problems in the hospital?

Medical Problems

Yes No 5. Has your child ever been in the hospital overnight?

Yes No 6. Is your child taking any medicine/vitamins?

Yes No 7. Any allergies or reactions to medicine, insects, DTP or other shots?

Yes No 8. Has your child had asthma or wheezing?

Yes No 9. Does your child have speech or hearing problems?

Yes No 10. Has your child had more than two ear infections in a year?

Yes No 11. Has your child had tonsillitis?

Yes No 12. Does your child have trouble with eyes or in seeing?

Yes No 13. Has your child had a bladder or kidney infection?

Yes No 14. Does he/she have burning when urinating?

Yes No 15. Does he/she have seizures or any nervous disorder?

Yes No 16. Is your child able to play as hard as other children?

Yes No 17. Have you ever been told your child has a heart murmur?

Yes No 18. Has your child ever had a bumpy swollen reaction to the TB skin test?

Yes No 19. Has your child ever been with anyone having TB?

Yes No 20. Has your child ever had worms?

Yes No 21. Does your child scratch his/her genital area? Is his her bottom or genitals red o sore?

Yes No 22. Is your child a hemophiliac (free bleeder)?

Yes No 23. Is your child on a heart monitor?

Yes No 24. Does your child have tubes in his/her ears?

Yes No 25. Has your child ever been involved in a serious accident?