

Health History

Child's Name:				Today's Date:	
Child's Birthdate:	Female	Male	Name of	School & Grade	
Address:					
(Street)		(City)		(State)	(Zip Code)
Emergency Contact Name:				Phone:	
Relationship to child:					
	Parer	nt Infor	mation		
Father's Name:				Date of I	3irth
Occupation:	PI	ace of Em	ployment: _		
Home phone:		Work	phone:		
Mother's Name:				Date of Birth:	
Occupation:	[Place of Er	mployment:		
Home phone:		Work	phone:		
Are Parents: Married	Divorced	Separa	ted		
Please list the names and relationshi	ps of anyone e	else involv	ed in the ch	nild's care:	

Family History

Names and birthdates of siblings: ____

Family Health History: Does anyone in your family suffer from:

Condition	Yes	No	Who has this condition (Relationship to Child)
Heart Disease			
High Blood Pressure			
Alcoholism			
Allergies			
Depression			
Diabetes			
Thyroid Disorder			
Cancer			
Asthma			
High cholesterol			

						Ne	wb	orn	History					
				-					than 5 years of a					
Birth weight:				_ N	Netho	od of D	Peliv	ery:	Vaginal	C-Section	Force	eps/V	acuum	
Length of pregnancy:		weeks			Feeding		g: Breast	Bottle Both						
Problems during	g preg	gnan	cy or de	eliver	ry:									
While in the hos	spital,	, did	the chi	ld ha	ve an	y of th	e fo	llowir	g?:					
Condition	Y	Ν	Condi	tion			YN	Ν	Other conc	Other concerns during hospital stay:				
Jaundice			Infecti	ion										
Poor Feeding			Breath	athing Concerns										
Did mother and	child	leav	, ve the h	lospit	tal tog	ether	⊥ ? If r	no. ple	ease explain:					
						,		,						
						Н	ea	lth H	listory					
Dioaco list all su	rront	mag	dication	<i>c</i> .					•					
Please list all cu	irent	met	lication	s										
Has your child b	een i	mm	unized?		_ Ye	s [] N	lo	At what cli	nic:				
Did this person	have	, or	does th	is pe	rson ı	now h	ave	any o	f the following:					
Conditi	on			N/		-	-							
				Y	N	Da	ate		Condi	tion	Y	Ν	Date	
Frequent Cold	s/Infe	ectio	ns	Y	N		ate		Condi Chronic Cough		Y	N	Date	
Frequent Colds Easy bruising c				Y	N	D:	ate				Y	N	Date	
-	or blee	edin		Y	N		ate		Chronic Cough		Y	N	Date	
Easy bruising c	or blee	edin		Ŷ			ate		Chronic Cough Wheezing or A		Y	N 	Date	
Easy bruising c	or blee ousne	edin ss		Ŷ	N		ate		Chronic Cough Wheezing or A Poor appetite	sthma	Y	N	Date	
Easy bruising c Loss of conscio Head Injury	or blee ousne vulsio	edin ss on		Y	N		ate		Chronic Cough Wheezing or A Poor appetite Weight loss	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com	or blee ousne vulsio	edin ss on		Y			ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com Frequent head	or blee ousne vulsio laches	edin ss on s	g	Y			ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur Bloody stool	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com Frequent head Eye problems	or blee ousne vulsio aches infect	edin ss on s	g	Y	N		ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur Bloody stool Blood in urine	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com Frequent head Eye problems Recurrent ear	or blee ousne vulsio aches infect	edin ss on s	g	Y	N		ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur Bloody stool Blood in urine Swollen joints	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com Frequent head Eye problems Recurrent ear Hearing proble	or blee ousne vulsio laches infect	edin ss on s tions	g	Y			ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur Bloody stool Blood in urine Swollen joints Frequent fallin	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com Frequent head Eye problems Recurrent ear Hearing proble	or blee ousne vulsio laches infect ems ng or	edin ss on s tions	g	Y	N		ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur Bloody stool Blood in urine Swollen joints Frequent fallin Dental cavities	sthma	Y	N	Date	
Easy bruising of Loss of conscio Head Injury Seizure or com Frequent head Eye problems Recurrent ear Hearing proble Constipation Chronic vomiti	or blee ousne vulsio laches infect ems ng or ach a	edin ss on s tions	g s s rrhea s		N		ate		Chronic Cough Wheezing or A Poor appetite Weight loss Heart murmur Bloody stool Blood in urine Swollen joints Frequent fallin Dental cavities Skin problems	sthma	Y	N	Date	

Does your child have allergies (food, medication, etc.)? If yes, explain: ______

Has your child had any hospitalizations, operations or major illnesses? If yes, explain: ______