HEALTH HISTORY FORM

Child's Name_____M___F___Birthdate_____

Has your child ever had any of the following:

Allergies	Febrile Seizures	Pneumonia
Asthma / wheezing	Fevers	Polio
Blocked tear duct	German Measles	Roseola
Bronchitis	Hand, foot & mouth disease	Scarlet Fever
Chicken Pox	Heart murmur	Sinus infection
Colds	Heart disease	Skin rashes
Colic	Hepatitis	Strep throat
Constipation	Kidney infections	Thrush
Diabetes	"Lazy Eye"	Urinary tract infection
Problems with diarrhea	Measles	Vision impairment
Ear infections	Meningitis	Vomiting problems
Eye Infections	Mumps	Whooping cough
Eczema	Cold sores	Yeast infection

Comments: (Please provide any pertinent information about items checked above.)_____

_____

GENERAL INFORMATION

Has your child ever been hospitalized? (If so, explain)_____

_____

Has your child ever had surgery? (If so, explain)_____

_____

Any side effects seen with any medications or food:_____

_____

Does your child see any special doctors? (i.e.: cardiologist, neurologist, eye doctor)_____

_____

Has your child had any injuries involving broken bones, loss of consciousness?_____

_____

Parent's Signature_____Date_____