

MEDICAL HISTORY
(To be filled out by parent)

Child's Name: _____ Age: _____ Date of Birth: _____

Childhood Information:

Pregnancy and Childbirth. List any problems while carrying your child (*illnesses, medication, emotional trauma*) and the type of birth: _____

Development. List anything unusual (*early or late*) in your child's development (*walking, weaning, talking, eating, etc.*): _____

Medical History. List any serious illnesses, hospitalizations, accidents, injuries, or operations your child has had. Please list dates: _____

Does your child have or have they experienced the following? (*check all that apply*):

<input type="checkbox"/>	Dizziness or Fainting Spells	<input type="checkbox"/>	Constipation or Diarrhea
<input type="checkbox"/>	Frequent or Migraine Headaches	<input type="checkbox"/>	Pain or Bleeding During Bowel Movements
<input type="checkbox"/>	Skin Allergies or Rashes	<input type="checkbox"/>	Unexplained Weight Change
<input type="checkbox"/>	Warts or Sores	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	Chest Pain or Shortness of Breath	<input type="checkbox"/>	A Rupture or Hernia
<input type="checkbox"/>	Spitting or Coughing up Blood	<input type="checkbox"/>	Pain in Back, Neck or Joints
<input type="checkbox"/>	Sweating at Night	<input type="checkbox"/>	Difficulty walking, running or lifting
<input type="checkbox"/>	Stomach aches or Indigestion	<input type="checkbox"/>	Heart trouble or disease
<input type="checkbox"/>	Urinary Bleeding, Frequent Urination	<input type="checkbox"/>	Diabetes or Sugar in the Urine
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Goiter or Thyroid Disease
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Tumor, Growth, Cyst or Cancer
<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	A Knee or Ankle Injury
<input type="checkbox"/>	An Ulcer	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	A Back Injury or Deformity	<input type="checkbox"/>	Anemia

Child's Personal Information:

Height_____

Weight_____

Hair Color_____

Eye Color_____

Glasses /Contacts?_____

Corrective Shoes?_____

Hearing Difficulty?_____

Speech Impairment?_____

Braces (orthodontic)?_____

Give dates of the following:

Last Physical Exam_____

Last Dental Exam_____

Last Vision Exam_____

Please attach a copy of your child's insurance/medical card and any written prescriptions