Medical History

Today's date_____

Child's Name_____ Date of Birth_____

Form completed by (name) _____Relationship to child_____

Child's **CURRENT** medicines: _____
Child's allergies to medicines:

_____

List any surgery the Child has had: _____

Child's Medical History:

Has the **CHILD** had any of the following problems? Please check **YES** or **NO**:

		YES	NO
1.	Anemia (low blood count)	❑	❑
2.	Allergies or asthma	❑	❑
3.	Cancer	❑	❑
4.	Chronic bronchitis, sinus or ear infections	❑	❑
5.	Chronic constipation	❑	❑
6.	Diabetes	❑	❑
7.	Drug or alcohol abuse	❑	❑
8.	Eating disorder	❑	❑
9.	Behavior problems	❑	❑
10.	Broken bones or joint problems	❑	❑
11.	Head injury or concussion	❑	❑
12.	Heart problems, high blood pressure	❑	❑
13.	High lead level	❑	❑
14.	Kidney problems or urine infections	❑	❑
15.	Learning problems	❑	❑
16.	Mental illness, depression or anxiety	❑	❑
17.	Migraines or headaches	❑	❑
18.	Serious accident/ ER visit	❑	❑
19.	Seizures	❑	❑
20.	Physical, emotional or sexual abuse	❑	❑
21.	Tuberculosis (TB)	❑	❑
22.	Vision, hearing or speech problems	❑	❑
23.	Tooth problems	❑	❑

-FORM CONTINUES ON THE OTHER SIDE-

Family's Medical History

Does a family member (mom, dad, sister, brother or grandparent) have any of the following problems? Please check **YES** or **NO**:

	YES	NO
24. Allergies or asthma	❑	❑
25. Birth Defect	❑	❑
26. Bleeding problems	❑	❑
27. Cancer	❑	❑
28. Diabetes	❑	❑
29. Drug or alcohol abuse	❑	❑
30. Heart problems	❑	❑
31. Hepatitis	❑	❑
32. High blood pressure	❑	❑
33. High cholesterol	❑	❑
34. Kidney disease	❑	❑
35. Lung disease	❑	❑
36. Mental illness, depression or anxiety	❑	❑
37. Migraines or headaches	❑	❑
38. Weight problems	❑	❑
39. Sickle Cell disease	❑	❑
40. Seizures	❑	❑
41. Stroke	❑	❑
42. Tuberculosis (TB)	❑	❑
43. A family member died suddenly before the age of 50	❑	❑

44. Other_____
_____

Use this space to explain any "YES" answers or provide more information:

_____
_____
_____
_____
_____
_____