MEDICAL HISTORY

Full Name: ________________________________ Date: ___________________

Date of Birth: ___________________ Age: ___________ Grade: ___________

Birth Weight: ___________________ Place of Birth: _______________________

Did your child have any problems at birth or shortly after birth? If so, please list:

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Please list any medical problems your child has or has had in the past:

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Has your child ever been admitted to the hospital? Please list reason for admission and your child's age when admitted:

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Please list any surgeries your child has had:

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List any significant accidents your child has experienced:

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Does your child have any allergies to medications? If so, please list medication and type of allergic reaction (e.g. Penicillin caused hives):

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Do any diseases run in your family?

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Does your child take any regular medications? Please list:

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Who was your previous doctor?

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Is there anything else we should know about your child?

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