HEALTH HISTORY

Child's Name ______________________ Home Address ______________________

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Birth Date ______________________ Alternate Phone ______________________

Father's Name ______________________ Mother's Maiden Name ______________________

Family Physician ______________________ Family Dentist ______________________

CHILD'S HISTORY

DOES YOUR CHILD HAVE:	NO	YES		HAS YOUR CHILD HAD:	NO	YES	YEAR
Asthma				Chickenpox			
Birth Defect				Regular Measles			
Frequent Bronchitis				German Measles			
Frequent Colds				Mumps			
Frequent Sore Throat				Whopping Cough			
Bowel/Urinary Problems				Scarlet Fever			
Diabetes				Rheumatic Fever			
Ear Aches				Lead Poisoning			
Seizure Disorder				Tubes in Ears			
Hearing Loss							
Heart Murmur							
Convulsions with Fever							
Chronic Cough							
Poor Eating Habits							
Skin Disease							
Speech Difficulties							
Vision Loss							
Allergies							
Allergy to insect stings							
Other:							

- Has the child ever been hospitalized or had an operation? No ______ Yes ______

  When? ______ What for? ______ Hospital/Where ______

- Has the child had any other serious illnesses, accidents, or broken bones? No ______ Yes ______

  When? ______ Problem? ______

- Is the child presently attending a clinic or hospital for a health problem? _______ No _______ Yes

  Where? ____________________________ What for? ____________________________________

- Is the child taking any medications other than vitamins? _______ No _______ Yes

  What? ____________________________ What for? ____________________________________

- Does the child need a special diet or have any food problems? _______No _______ Yes

  Give details ____

- Does your family have a history of illness? _______No _______ Yes
  (Cancer, Diabetes, Heart Disease)
  What? ____

- Does the child have any special health needs or problems that will required attention or assistance in school?

  (Please discuss this with school nurse) _______ No _______ Yes

  What? ____

CIRCLE ANY OF THE FOLLOWING THINGS WHICH WORRY YOU ABOUT THIS CHILD

Bedwetting	Restlessness	Daydreams	Lying
Daytime wetting	Shy	Nightmares	Selfishness
Thumbsucking	Sadness, sulking	Temper tantrums	Jealousy
Speech	Feelings easily hurt	Stubbornness	Fighting with others
Disobedient	Destructive	High Strung	Easily upset
Eating habits	Clumsiness	Wanting too much attention	

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Please Print Name

________________________________ ________________________

Signature of Parent/Guardian Date