PERSONAL HEALTH HISTORY - CHILD

Name _____ Prefer to be called _____ Age _____ Grade in School _____

Height _____ Weight _____ Parents' names _____ Siblings names _____

Other family members seen in our office _____ Reason for visit _____

Referred to this office by _____ Child's pediatrician _____ _____
_____

Is immunization up-to-date? _____ Medications - dosage & frequency (include aspirin, any over-the counter medicines, etc.)

_____

_____

MEDICAL HISTORY - Please check all that apply.

____ Tonsillitis	____ Juvenile Diabetes Melitis	____ Chicken Pox
____ Ear infections	____ Juvenile Rheumatoid Arthritis	____ Scarring
____ Frequent colds	____ Mumps	____ Asthma
____ Rashes	____ Measles	
____ Rubella	____ Other _____	

SURGICAL HISTORY

Operations	Year	Surgeon

Problems with anesthesia

_____

MISCELLANEOUS

Allergies:

_____

Is the child right or left handed? _____ has the child ever had stitches? If yes, please explain:

_____

If the child is under five years of age, please describe:

Prenatal history _____ Birth Weight _____ Gestation_____

Type of delivery (vaginal or Caesarean) _____

Any other problems with delivery

_____

Is there anything else significant we should know (personal or family history)?

_____