CHILD FULL NAME: _____ DOB _____ Grade:_____

Mother's Full Name: _____ Father's Full Name: _____

If applicable, date of the last menstrual cycle for your daughter: _____

Is your child up to date on Immunizations: Yes: _____ No: _____

Past Medical History: (Please check any medical problems your child has/had)

___ Acne
___ Allergies: Type: _____
___ Anemia
___ Asthma
___ Anorexia
___ Bulimia
___ Depression
___ GERD (Reflux)
___ Heart Murmur
___ Jaundice
___ Seizures
___ Thyroid Problems
___ Ulcer
___ Diabetes (type ___)

Birth History for child under age 10: Vaginal____ C-Section ____ Birth weight & length: _____

Any problems with pregnancy or delivery? No: _____ Yes: _____ If yes, please explain: _____

_____

Other Major Medical Problems Not Listed Above: _____

_____

Surgical History: (Please list prior surgeries and dates) _____

_____

Family History: Age Major Health Problems Age Major Health Problems

Father _____ _____ Brother's _____ _____

Mother _____ _____ Sister's _____ _____

Social History:

Any Pets: No: _____ Yes: _____ If yes, how many and what kind: _____

Any Development Issues? _____

Medication Allergies: _____ **Reaction:** _____

Medications: (include Birth Control, Over the Counter Medications and Vitamins)

DRUG:	**DOSE:**
_____	_____
_____	_____
_____	_____