**MEDICAL HISTORY**

Patient’s Name [First, MI, Last]

Suffix:

Date of Birth [mm/dd/yyyy]

**Medications - Please list all medications that your child is currently taking. Please include the dosage and frequency if known.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies- Please list any known medical, dental, or environmental allergies your child has.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the name of your child’s Pediatrician/Physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Pediatrician/Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number of Pediatrician/Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions/Problems**

Does your child have any of the following medical condition and/or been treated for them?

Yes/No Asthma

Yes/No Seizures

Yes/No Epilepsy

Yes/No Fainting

Yes/No Convulsions

Yes/No Diabetes

Yes/No Kidney Problems

Yes/No Bladder Problems

Yes/No Liver Problems

Yes/No Jaundice

Yes/No Hepatitis

Yes/No Cancer

Yes/No Heart Murmur

Yes/No Congenital Heart Disease

Yes/No Anemia

Yes/No Blood Disorder

Yes/No Prolonged Bleeding

Yes/No Blood Transfusion

Yes/No High Blood Pressure

Yes/No Low Blood Pressure

Yes/No Rheumatic Fever

Yes/No Rheumatic Heart Disease

Yes/No Tuberculosis

Yes/No Pneumonia

Yes/No HIV/AIDS

Yes/No Autism Spectrum Disorder

Yes/No Cerebral Palsy

Yes/No Premature Birth

Yes/No Endocrine/Growth Problems

Yes/No Hormonal Problems

Yes/No Behavior Disorders

Yes/No Learning Disability

Yes/No Speech Disorders

Yes/No Hearing Disorders

Yes/No Vision Disorders

Yes/No Previous Surgery/Hospitalizations

Yes/No Pending Surgery

Yes/No Other [Please Specify] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_