Name_____ Physician's Name & Number_____

CHILD'S MEDICAL HISTORY

Please mark the box if your child has the condition now or has been treated for the condition in the past.

EYES, EARS, NOSE AND THROAT

- □ Allergy/Sinusitis
- □ Chronis Earaches
- □ Deafness/Hearing Loss
- □ Speech Problems
- □ Chronic Sore Throat/Tonsillitis
- □ Blindness/Low Vision

HEART AND BLOOD

- □ Antibiotics for previous dental work
- □ Heart Murmur
- □ Circulation Problems
- □ Congenital Heart Problems
- □ Heart Surgery
- □ Artificial Heart Valves
- □ Rheumatic or Scarlet Fever
- □ Excessive Bleeding/Hemophilia
- □ Hepatitis
- □ Sickle Cell Anemia
- □ HIV/AIDS
- □ Leukemia
- □ History of Blood Transfusion

STOMACH, LIVER, KIDNEYS AND BLADDER

- □ Stomach Problems
- □ Diabetes
- □ Kidney Disease
- □ Bladder Problems

INFECTIONS, ILLNESSES AND HOSPITALIZATION

- □ Chicken Pox
- □ Cancer or other malignancies
- □ Chemotherapy Dates_____
- □ Blood Transfusion Dates_____

THE LUNGS

- □ Asthma
  - □ Uses inhaler as needed
  - □ Uses daily oral medicines or daily inhaler
- □ Bronchitis
- □ Tuberculosis
- □ Pneumonia

THE NERVOUS SYSTEM, MUSCLES AND BONES

- □ Epilepsy or Seizures
- □ Fainting
- □ Cerebral Palsy
- □ Nervous Problems
- □ Mental Retardation
- □ Down Syndrome
- □ Autism
- □ Attention Deficit Disorder
- □ Head Trauma/Brain Injury
- □ Spina Bifida
- □ Muscular Dystrophy
- □ Orthopedic Problems
- □ Artificial Joints

ALLERGIES

- □ Aspirin
- □ Codeine
- □ Dental Anesthetics
- □ Erythromycin
- □ Jewelry
- □ Latex
- □ Metals
- □ Penicillin
- □ Tetracycline
- □ Other_____

MEDICATIONS:_____

IS THERE ANYTHING ELSE WE NEED TO KNOW ABOUT YOUR CHILD'S HEALTH HISTORY?

_____

Signature_____ **Date**_____