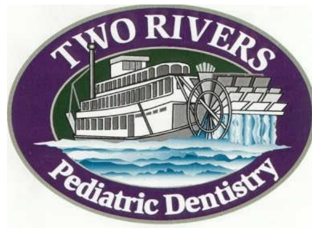

Child Medical History Form

Child's name: ____________________________ Date of Birth: ___________ Gender: Male__ Female __

Please complete the following form so we may better serve your child.

Has your child ever had any of the following?	**Yes**	**No**	**Comments**
Heart Murmur			
Congenital heart disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular or Endocrine Disease			
Liver Disease, Hepatitis or Jaundice			
Kidney Disease			
Skin, Bone, Muscle or Joint Disease			
Seizures, Convulsions, Loss of Consciousness			
Cerebral Palsy, Neurological Disease			
Anemia, Hemophilia or other Blood Disease			
Sickle Cell Disease or Trait			
Cancer			
Speech or Hearing Disorder			
Sight or Eye Disorder			
Frequent Headaches			
Mental, Emotional or Developmental Delays			
ADHD, ADD			
Autism			
Genetic Disorder or Syndrome			
Frequent Infections			
Has your child ever been seriously ill?			
Has your child ever been hospitalized?			
Has your child had any surgeries?			
Does your child take any medications? (If so please list)			
Is your child allergic to any foods or medicines? (If so please list)			

In general, how is your child progressing: Slow____ Normal____ Accelerated ____

Is there any other disease or medical condition that we should know about in order to care for your child?