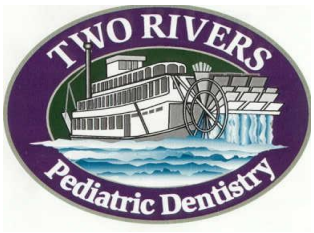


**Child Medical History Form**

**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?<br>(If so please list) | | | |
| Is your child allergic to any foods or medicines?<br>(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?

_____