



Health History

1. Child's Name _____

2. Previous Illness:

_____ Chicken Pox Age _____

_____ Diabetes Age _____

_____ Measles Age _____

_____ Mumps Age _____

_____ Other Age _____

3. Frequency of Illness

Does your child frequently have any of the following?

_____ colds, if yes, describe _____

_____ ear aches, if yes, describe _____

_____ high fever, if yes, describe _____

_____ nausea/vomiting, if yes, describe _____

_____ stomach aches, if yes, describe _____

_____ nose bleeds, if yes, describe _____

4. Has your child had any serious accidents or operations? ____ Yes ____ No
If yes, please describe

5. Allergies

_____ asthma, if yes, how does it manifest itself?

_____ hayfever, if yes, how does it manifest itself?

_____ hives, if yes, how does it manifest itself?

_____ other (specify), if yes, how does it manifest itself?

6. Is your child on any daily medications? _____ Yes _____ No
If yes, please list the medications and their purpose

7. Any other health concerns?
