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?
_____
_____
_____