Child's Name ________________________________ DOB ______________

Does your child have:

- Medical problems/chronic illness (heart/seizure/cerebral palsy/autism/dev. delay, etc.)? ☐ Yes ☐ No
  Type:____
- Asthma or use a nebulizer? ☐ Yes ☐ No
  Date of last use: _______________ Ever hospitalized for it/date? ___________________
- Seasonal allergies? ☐ Yes ☐ No
  How and when was it diagnosed? (symptoms/blood test/skin test)_________________ Date ____________
- Medication allergy? ☐ Yes ☐ No
  Name of medication(s):______________________________ Reaction Type:________________________
- Overnight hospitalization? ☐ Yes ☐ No
  Reason: ____
- Surgery (including circumcision, tonsils/adenoids, etc.)? ☐ Yes ☐ No
  Date & Type:____

Medical history for CHILD's mother, father, grandparents (both sides) and siblings:

	Mom	Dad	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Other
Asthma									
Allergies									
Bleeding Disorder									
Cancer (type)									
Diabetes (what age)									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Other Heart Problem (type)									
Tuberculosis									
Seizure									
Kidney Problems									
Psychiatric (depression/ anxiety/bipolar/etc.) Type?									
HIV/AIDS									
Thyroid									

Who lives in the house with child? ☐ Mother ☐ Father ☐ Brother(s) #______ ☐ Sister(s)#______ Other____

Parents married? ☐ Yes ☐ No **Any pets?** ☐ Yes ☐ No Type____________________ **Pool?** ☐ Yes ☐ No

Any smokers ? ☐ Yes ☐ No **Who?** _____________ **Does the child (over 12yrs.) smoke?** ☐ Yes ☐ No

Daycare/babysitter? ☐ Yes ☐ No **School?** ☐ Yes ☐ No **Name of school** ___________________ **Grade** _____

Pharmacy (Name, location, phone #)____