Medical History Form

Child's Name:_____

Date of Birth:_____

Is your child currently on any medications (if so, what medications & dosages):_____
_____
_____

Is there anyone in the family with a history of the following (if so, please specify relationship):

- ☐ Asthma:_____
- ☐ Allergies:_____
- ☐ Birth Defects: _____
- ☐ Childhood Cancers/Leukemia: _____
- ☐ Infant Death: _____
- ☐ Mental Retardation: _____
- ☐ Developmental Delay: _____
- ☐ Speech/Hearing/Language Delay: _____
- ☐ Learning Problem: _____
- ☐ Cystic Fibrosis: _____
- ☐ Early Heart Attack ≤ 55: _____
- ☐ Hypertension: _____
- ☐ Diabetes: _____
- ☐ Anything strange or unusual on either side of the family: _____
  _____

I verify that the answers to the questions above are correct.

_____ _____ _____

Signature Print Name Date