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Health History

Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Family Doctor: _____ Family Dentist: _____

**If your child has or has ever had, the following, please check the appropriate box.
If the answer is "Yes" please give details: i.e., doctor, date, etc.**

- 1. A Heart Condition No Yes _____
- 2. Rheumatic Fever No Yes _____
- 3. Kidney Problems No Yes _____
- 4. Convulsions No Yes _____
- 5. Frequent Ear Infections No Yes _____
- 6. Hearing Difficulties No Yes _____
- 7. Visual Problems No Yes _____
- 8. Glasses No Yes _____
- 9. Epilepsy No Yes _____
- 10. Allergies No Yes _____
- 11. Asthma No Yes _____
- 12. Bone Conditions No Yes _____
- 13. Diabetes or Thyroid No Yes _____
- 14. Operations No Yes _____
- 15. Extended Hospitalizations No Yes _____
- 16. Serious Accident No Yes _____
- 17. Serious Illness No Yes _____
- 18. Fainting No Yes _____
- 19. Severe Nose Bleeds No Yes _____
- 20. Premature Birth No Yes _____
- 21. Frequent Throat Infections No Yes _____
- 22. Treatment or observation for any condition? No Yes _____
- 23. Taking any medication? No Yes _____



Parent or Guardian Signature: _____ **Date:** _____