

**Name:**\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_

Immunizations Up to Date ? : ☐Yes ☐No

Allergies ? If yes, to what? \_\_\_\_\_

Receive any type of medical care elsewhere? If yes, explain. \_\_\_\_\_

On or previously was on any medication? (If yes , which ?) : \_\_\_\_\_

Past Medical History  
(If yes to any explain in detail)

Serious medical conditions? Yes ☐ No ☐ : \_\_\_\_\_

Surgeries ? Yes ☐ No ☐ : \_\_\_\_\_

Neurologic Disorder? (ADD,ADHD): \_\_\_\_\_

Hospitalizations? Yes ☐ No ☐ : \_\_\_\_\_

History of Disease? Yes ☐ No ☐ : \_\_\_\_\_

Frequent ear infections or sinus infections? Yes ☐ No ☐ : \_\_\_\_\_

Animals in the home? Yes ☐ No ☐ What kind ? \_\_\_\_\_

Asthma? Yes ☐ No ☐ : \_\_\_\_\_

Pneumonia , Bronchitis, Croup? Yes ☐ No ☐ : \_\_\_\_\_

Heart Issues? Yes ☐ No ☐ : \_\_\_\_\_

Bladder or Kidney Infections? Yes ☐ No ☐ : \_\_\_\_\_

Bedwetting after age 5? Yes ☐ No ☐ : \_\_\_\_\_

Eye conditions? (Please select yes if your child wears glasses/contacts) : \_\_\_\_\_ -

Problems with hearing ? Yes ☐ No ☐ : \_\_\_\_\_

Chronic or recurrent skin conditions (acne,eczema, etc.) : \_\_\_\_\_

Anemia? Yes ☐ No ☐ : \_\_\_\_\_

Diabetes ? Yes ☐ No ☐ : \_\_\_\_\_

Frequent headaches ? Yes ☐ No ☐ : \_\_\_\_\_

Seizures ? Yes ☐ No ☐ : \_\_\_\_\_

Use of alcohol or drugs ? Yes ☐ No ☐ : \_\_\_\_\_

Depression? Yes ☐ No ☐ : \_\_\_\_\_

Current Smoker? Yes ☐ No ☐ : \_\_\_\_\_

Any exposure to secondhand smoke ? Yes ☐ No ☐ : \_\_\_\_\_

If female, have menstrual periods started? When? Yes ☐ No ☐ : \_\_\_\_\_

I have read the above and I note the above information is correct to the best of my knowledge

**Parent or Guardian Signature :** \_\_\_\_\_