PERMANENT HEALTH HISTORY *(Confidential)*

Name:_____ Sex: ❑ M ❑ F **Birthdate:**_____

Child's Physician _____
Address _____
Last seen _____

Child's Dentist _____
Address _____
Last Seen _____

Child's Physicians (Specialists) _____
_____
Address _____
Last seen _____

Medical History (Past or present):

Accidents _____
_____
Operations _____
_____
Hospitalization? _____
When/Where _____
_____
_____

Please check all that apply:

- ❑ Heart disorder
- ❑ Kidney disease
- ❑ Diabetes
- ❑ Convulsions/Seizures
- ❑ High Fevers
- ❑ Frequent ear infections
- ❑ Allergies
- ❑ Asthma

If Allergies are checked above check all that apply:

- ❑ Hay Fever
- ❑ Peanut
- ❑ Bee Sting
- ❑ Food _____
- ❑ Drug_____
- ❑ Other_____

Drug reactions _____
Name Drugs

Please check if anyone in the child's family has a history of the following medical conditions

- ❑ Allergies
- ❑ Asthma
- ❑ Hay fever
- ❑ Bleeding Disorder
- ❑ Anemia
- ❑ Cancer
- ❑ Birth defects
- ❑ Epilepsy
- ❑ Convulsions
- ❑ Diabetes
- ❑ Heart disease
- ❑ Kidney disease
- ❑ Tuberculosis
- ❑ Overweight
- ❑ Other:_____

_____

Birth History:

Weight _____ Height _____
Length of pregnancy _____
Anesthetic _____ Duration of Labor _____
Type of delivery?
Cesarean ❑ Breech ❑ Normal ❑

Complications during pregnancy?

- ❑ Infection
- ❑ Bleeding
- ❑ High blood pressure
- ❑ Other____

_____

Any problems shortly after birth?

- ❑ Convulsions
- ❑ Jaundice
- ❑ Difficulty breathing
- ❑ Anemia
- ❑ Feeding problems
- ❑ Malformation

Child's condition at birth _____
_____

Any problems during your child's first 5 years?

_____

Developmental History:

When did your child? *Approximate age*
sat alone _____ said words _____
crawled _____ walked _____
Use 2 or 3 word sentences _____
Toilet training: BM _____ Wetting _____

Does your child now have or has he had in the past, difficulties in any of these areas?
Please explain
Frequent health complaints? _____
_____
Appear restless or overactive?_____
_____
Present any problem in discipline?
_____
Problems getting along with others? _____
_____

Please check all that apply:

- ❑ Eating problems
- ❑ Sleeping problems
- ❑ Speech problems
- ❑ Vision problems
- ❑ Wears glasses
- ❑ Hearing problems
- ❑ Hearing Aid
- ❑ Mouth breather
- ❑ Bites nails
- ❑ Has nightmares
- ❑ Is shy
- ❑ Sucks thumb
- ❑ Has facial tics
- ❑ Wets bed
- ❑ Has tantrums
- ❑ Is clumsy

Takes medication at present? _____
If so what? _____

Social Development: *(Yes or No)*

Plays alone? Yes ❑ No ❑
Plays with neighborhood children? Yes ❑ No ❑
Attended pre-school? Yes ❑ No ❑

Anything else you would like us to know about your child: _____
_____
_____
_____

_____
Parent/Guardian Signature

_____
Date