Medical History Form

Date:_____

Name:_____DOB:_____ Age:_____

Birth History: Were there any problems during pregnancy:_____If yes please explain:_____

_____

_____

Was he/she born more than 2 weeks early: _____If so, how early?_____

Were there any complications during delivery?_____If so what? _____

_____

Delivery History: Natural Forceps Cesarean Section

What was the birth weight? _____

Illness History: Please select all that apply: Asthma Seasonal Allergies Chicken Pox Diabetes

Eczema Pneumonia Frequent Sore Throat Frequent Ear Infections Seizures

Frequent Urinary Tract Infections Frequent Kidney or Bladder Infections

Other Childhood Illnesses: _____

Significant Injuries: _____

Hospitalizations (when and reason): _____

Surgery (when and reason): _____

Allergies: _____

Are There Behavioral Issues:_____

Family History: How is the Health of:

Mother:_____

Father:_____

Siblings:_____

Please circle all that apply. Anyone in the family (including close relatives) with: Asthma Allergies

Diabetes Heart Disease High Blood Pressure Seizures Thyroid or Other Endocrine Disorders

Mental Retardation or Other Disabilities

Do You Have City Water: Yes No

Parent/Guardian Signature:_____