

<b>PRINT CHILD'S LEGAL NAME:</b>	Nickname:	DOB:
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<i>Parents: Please read and answer EVERY question!</i>	Child's previous <b>physician</b> was:
<b>ANY ALLERGIES? (List all food or drugs)</b>	I want to sign a release of records: Yes or No ?
	<b>My Preferred Pharmacy is:</b>
If none - please circle: <b>None Known</b>	

<b>CHILD'S PAST MEDICAL HISTORY</b>	<b>MEDICATIONS</b>
My child's health is generally: (check)    good <input type="checkbox"/> fair <input type="checkbox"/> poor <input type="checkbox"/>	Include all vitamins & over-the-counter medicine
<i>Circle &amp; write year it started</i>	YEAR
Asthma	<b>List all current medications &amp; dose / instructions:</b>
Cancer	
Diabetes	
List any health problems child has:	
	SPECIFY / Year
Any serious injuries or accidents?	
Any disability or handicaps?	
Any Nutritional problems?	

<b>IMMUNIZATIONS?</b>	<b>Past Surgeries?</b>	<b>LIST YEAR</b>
My child <b>IS / IS NOT</b> (circle one) up-to-date with vaccinations		
YEAR / or Needed?		
Diphtheria, Tetanus, Pertussis (Dtap)		
Haemophilus influenzae type b (Hib)		
Measles, Mumps, Rubella (MMR)		
Varicella (Chicken pox)		
Pneumonia		
Flu		
Hepatitis A		
Hepatitis B		

<b>My CHILD's FAMILY MEDICAL History</b>			
	AGE	List any Medical Problems	Living?
FATHER			
MOTHER			
BROTHER(S)			
SISTER (S)			
GRANDPARENT(S)			
Other family member(s):			

<b>Other pertinent information I want the doctor to know:</b>	<b>List Child's Hobbies, interests, sports</b>

I am this child's legal guardian: YES    NO    (circle one)                      If no, the child's legal guardian is: \_\_\_\_\_

**Parent/Guardian's Signature:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_