Child's Health History Checklist

In an effort to provide the best care for your child, we are requesting the following information. Under HIPPA regulations, all medical information will be kept confidential.

Yes No

___ ___ Has your child ever been in the hospital overnight?

___ ___ Is your child taking medication? If yes, please list: ________________________

___ ___ Any allergies or reactions to medicine or vaccinations or insects? If yes, please list: ____

___ ___ Has your child had asthma or wheezing issues?

___ ___ Does your child have hearing or speech difficulties? Circle: Hearing Speech

___ ___ Does your child have difficulty with his/her eyes or vision?

___ ___ Has your child had a bladder or kidney infection?

___ ___ Has your child experienced seizures?

___ ___ Has your child been diagnosed with a heart murmur?

___ ___ Is your child able to play games or sports that require physical exertion?

___ ___ Has your child experienced a visible reaction to the TB skin test?

___ ___ Has your child been in contact with anyone diagnosed with TB?

___ ___ Is your child a hemophiliac?

___ ___ Has your child had ear tubes inserted?

GIRLS:

___ ___ Has your daughter begun menses?

___ ___ Are there any problems with her periods?

Please list any medical issues not addressed above: ________________________________

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Date of last Doctor's visit (month/year): ____