



Child's Name _____ Age _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 Father's Name _____ Mother's Name _____
 Father Employed By _____ How long? _____ Home Phone _____ Business Phone _____
 Mother Employed By _____ How long? _____ Home Phone _____ Business Phone _____
 Father's Social Security # _____ Mother's Social Security # _____
 Person Financially Responsible _____ Relationship to Child _____
 Address _____ City _____ State _____ Zip _____
 Whom may we thank for referring your child? _____ Address _____
 What is child's favorite sport? _____ Favorite toy? _____
 Favorite hobby? _____ Favorite Person? _____ Favorite Fiction Character? _____
 School _____ Grade _____

HEALTH HISTORY

Physician's Name and Address _____
 Date of last physical exam _____ Physician's Phone Number _____
 List any medications your child is currently taking: _____

Is there any history or difficulty with any of the following? (Please indicate with a check mark)

- | | | |
|--|--|---|
| <input type="checkbox"/> Any Allergies to: | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver |
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> anesthetics | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mastoid |
| <input type="checkbox"/> environmental | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Measles |
| <input type="checkbox"/> pain medications | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Any Heart Problems: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> Fainting | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> valve replacement | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> other | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Kidney | <input type="checkbox"/> Venereal Disease |

Parent or Guardian Signature _____ Date _____