Medical History

Child's Physician_____

Physician's Address_____Phone_____

Any history of serious problems or complications with pregnancy, carrying, or delivery of the child?	Yes No
Any history of seizures, convulsions, dizziness, or loss of consciousness?	Yes No
Has your child ever been diagnosed as having cerebral palsy or mental retardation?	Yes No
Was your child born with any kind of heart disease?	Yes No
Any history of anemia, excessive bleeding, or blood problems?	Yes No
Any difficulty breathing, asthma, bronchitis, pneumonia, or shortness of breath?	Yes No
Any history of stomach, intestine, liver, gall bladder, or digestive problems?	Yes No
Any history of disease of problems with kidneys or bladder?	Yes No
Any history of hormonal or glandular problems, or diabetes?	Yes No
Is your child allergic to any specific drugs or medications? If so, please list below.	Yes No
Is your child currently taking any medications? If so, please list below.	Yes No
Has your child been in a hospital overnight since birth?	Yes No
Does your child have any problems getting along with playmates?	Yes No
Does your child have any major problems we should know about?	Yes No

If any questions were answered "Yes", please describe more fully_____

_____

_____

Names and ages of brothers and sisters _____

Whom may we thank for referring you to our office?_____