

HEALTH HISTORY UPDATE

Child's Name _____ D/O/B _____ Age _____

Home Address: _____

City: _____ State _____ Zip: _____

Home Phone: _____ S.S.# _____ Sex: Male _____ Female _____

School Child Attends: _____

Father _____ Home Phone _____ Cell # _____

D/O/B _____ S.S.# _____

Home Address: _____

City: _____ State _____ Zip: _____

Employed By: _____ Work # _____ Ext. _____

Email Address: _____

Name of Insurance Company If Child Is Covered: _____
 _____ Group # _____

Mother _____ Home Phone _____ Cell # _____

D/O/B _____ S.S.# _____

Home Address: _____

City: _____ State _____ Zip: _____

Employed By: _____ Work # _____ Ext. _____

Email Address: _____

Name of Insurance Company If Child Is Covered: _____
 _____ Group # _____

Name of Nearest relative not living in the same household _____

Address _____ Phone _____

Has Your Child Experienced Any of the Following?

	YES	NO		YES	NO
Heart Disease	_____	_____	Liver Problems	_____	_____
Heart Murmur	_____	_____	Hepatitis	_____	_____
Rheumatic Fever	_____	_____	Kidney Problems	_____	_____
Bleeding Problems	_____	_____	Muscle Problems	_____	_____
Anemia	_____	_____	Premature Birth	_____	_____
Blood Transfusions	_____	_____	Diabetes	_____	_____
Asthma	_____	_____	Mental Disorder	_____	_____
Allergies	_____	_____	Nervous Disorder	_____	_____
Bronchitis	_____	_____	Fainting	_____	_____
Seizure Disorder	_____	_____	Speech Disorder	_____	_____
Hearing Problem	_____	_____	Vision Problems	_____	_____
Cerebral Palsy	_____	_____	Headaches	_____	_____
Mental Retardation	_____	_____	HIV Positive	_____	_____
AIDS	_____	_____	Autism	_____	_____

Is Your child taking any medication? List if Any _____

Allergic To: _____

Date: _____ Signature: _____