Medical History

Patient Name: _____ Patient D.O.B.: _____

1.) At approximately how many weeks was your child born? Did your child require extra days in the hospital at birth?

_____

_____

2.) Does your child have any medical problems? (Ie: asthma, eczema, diabetes, etc.) Does/Has your child see any specialists?

_____

_____

3.) Has your child had any medical problems in the past that have now been resolved?

_____

_____

4.) Has your child required any hospitalizations, E.R. visits?

_____

_____

5.) Has your child had any surgeries or procedures?

_____

_____

6.) Is your child on any current/past medications?

_____

_____

7.) Does your child have any allergies?

_____

_____

8.) Has your child ever had any development or behavior issues?

_____

_____