FAMILY MEDICAL HISTORY: DATE: ____________________

Do any of child's immediate family members have the following; if yes, please state sibling, mother, father, grandmother, etc.

	YES	NO	Family Members
Heart Disease	___	___	____
Diabetes	___	___	____
Cancer	___	___	____
Sickle Cell Anemia	___	___	____
High Blood Pressure	___	___	____
Allergies/Asthma	___	___	____

Has your child had or currently have any of the following?

	YES	NO		YES	NO
1. High fevers	____	____	16. Anemia	____	____
2. Seizures	____	____	17. Diabetes	____	____
3. Head Injury	____	____	18. Ringworm	____	____
4. Sutures (Stitches)	____	____	19. Arthritis	____	____
5. Broken Bones	____	____	20. Epilepsy	____	____
6. Operations	____	____	21. Heart trouble	____	____
7. Hospitalizations	____	____	22. Kidney problems	____	____
8. Allergies	____	____	23. Frequent ear infections	____	____
9. Chicken Pox	____	____	24. Frequent headaches	____	____
10. Mumps	____	____	25. Eczema	____	____
11. Measles	____	____	26. Asthma	____	____
12. German Measles	____	____	27. High Blood Pressure	____	____
13. Scarlet Fever	____	____	28. Lyme Disease	____	____
14. Rheumatic Fever	____	____	29. Hepatitis	____	____
15. Fifth Disease	____	____			

**IF YES, PLEASE DESCRIBE
____

____

Does your child have any hearing difficulties? Yes ____ No ____ Specify __________________________

Does your child wear glasses? Yes ____ No ____ Specify ______________________________________

Does your child take medication that would be necessary during school hours? Yes ____ No ____
Names of Medications ____

Has your child had routine dental checkups? Yes ____ No ____

Does your child have health insurance? If so, name of company _________________________________

Date of your child's last medical exam: ____

Date of your child's last lead blood test and results: ____

Date of first Polio immunization: ____