MEDICAL HISTORY *(please fill out additional history forms for each child)*

Allergy / Reaction Information

Medication Allergies: No: _____ Yes: ____ (explain below)

_____

(Medication) (Reaction)

Non-Medication Allergies: None: ___ Yes: (please describe)_____

Vaccine Reactions: None: ___ Yes: (please describe) _____

Current/Chronic Medications/Supplements/Vitamins

1. _____

(Medication) (Dose) (Date Started)

2. _____

(Medication) (Dose) (Date Started)

3. _____

(Medication) (Dose) (Date Started)

Problem List/Ongoing Medical Conditions

1. _____

(Diagnosis) (Date)

Details:

2. _____

(Diagnosis) (Date)

Details:

3. _____

(Diagnosis) (Date)

Details:

Pertinent Past Medical History

(check if Yes and provide details including date)

___ Birth Problems Please describe:_____

___Serious Injuries Please list: _____

___Surgeries Please list: _____

___Hospitalizations Please list: _____

Pertinent Family Medical History:

_____

Pertinent Social History:

_____

Does anyone in the household smoke ___yes ___no

Does anyone in the household own a gun ___yes ___no Are they locked up? ___yes ___no

Does your child have a dentist ___yes ___no Who_____