CHILDREN'S CENTER
CHILDREN'S SQUARE, U.S.A.

# CHILD'S MEDICAL HISTORY AND EXAMINATION

DATE OF EXAMINATION: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

NAME OF PARENT(S)/GUARDIAN(S): _____

DENTIST'S NAME: _____ DATE OF LAST VISIT: _____

HOSPITALIZATIONS OR SURGERIES LIST TYPE AND DATE: _____

DOES CHILD HAVE ANY ILLNESS OR CONDITION THAT REQUIRES MEDICAL CARE FROM A PHYSICIAN? IF YES, PLEASE EXPLAIN_____

_____

DOES YOUR CHILD TAKE MEDICATION REGULARLY? IF YES, WHAT, HOW MUCH & WHY? _____

_____

GLASSES: ( ) YES ( ) NO BRACES: ( ) YES ( ) NO HEARING AIDS ( ) YES ( ) NO

| ALLERGIES | TYPES & SYMPTONS | DOCTOR RECOMMENDATIONS FOR ALLERGIES |
|---|---|---|
| ENVIRONMENTAL | | |
| FOOD | | |
| MEDICATION | | |
| INSECTS | | |
| OTHER: | | |

HEIGHT_____ WEIGHT_____ PULSE_____ GENERAL APPEARANCE_____

LEAD TEST _____

DIAGNOSIS & EVALUATION AND/OR RECOMMENDATIONS:

DOCTOR'S SIGNATURE: _____

DOCTOR'S PRINTED NAME: _____ADDRESS: _____