Individual Health History

Name: _____DOB_____

Current Medical Conditions: (Please circle or list)

_____

Asthma	Acne or psoriasis	Allergies	Eczema	Headaches or concussions	Acid Reflux
ADHD/ADD	Autism	Speech Delay	Developmental Delay	Depression	Anxiety
Vision Problem	Hearing Loss	Heart Murmur or heart defects	Genetic Syndrome	Bowel Disease	Urinary or Kidney Disease
Frequent skin infections	Scoliosis	Bone or Joint disorders	Thyroid disease	Diabetes	Seizures

Previous Surgeries or Hospitalizations with date or age:

_____

Current Medications and dosages:

_____

Allergies to Medications, Insects or Foods please list and include reaction type:

_____

Problems at Birth:_____**Premature**: Yes / No

Smoke Exposure: Yes / No **Pets**: _____**Daycare**: Yes / No

School Attending and grade:_____**IEP/504 plan**: Yes / No

Family Medical History (please circle) pertaining to parents, grandparents and siblings

Heart Attack Age < 50y	Enlarged Heart	Heart arrythmia	Asthma	Kidney Failure	Environmental Allergies
Sudden unexplained death	Genetic Disorders	Endocrine disorders (Diabetes, Thyroid)	Mental health disorders	Addictions	ADHD/ ADD
Gastrointestinal Disorders	Cancers	Bone or Joint Disease	Epilepsy Seizures	Nerve or Muscle Disorders	Hearing Loss

Special Interest or Hobbies:_____

Any Specialist Physicians and/or Dentist: _____