

CHILD'S HISTORY - HEALTH INVENTORY AND PHYSICIAN'S REPORT

Side I: History - Health Inventory

To be completed by parents:

Medical Referral Needed: _____

Child's Name _____ Birthdate _____ Sex _____

Address: _____ Phone _____
NUMBER STREET CITY ZIP

Parent's Name _____ Work Phone _____

Emergency Contact Name _____ Phone _____

Source of Health Care _____ Record Number _____

MEDICAL HISTORY - Please describe any accidents, operations or hospitalizations:

COMMUNICABLE DISEASES • Please check those which your child has contracted:

_____ Chicken Pox _____ Measles _____ Mumps _____ Others _____

_____ Whooping Cough _____ Rubella (German Measles)

CHRONIC CONDITIONS • Please check those which your child suffers from:

_____ Allergy (Food) _____ Diabetes _____ Sickle Cell Diseases

_____ Allergy (Drug) _____ Epilepsy _____ Others _____

_____ Rashes _____ Heart Disease _____

_____ Asthma _____ Rheumatic Fever _____

_____ Convulsions _____ Breathing Difficulties _____

Is your child taking any medication regularly? _____ If so, which one(s) _____

COMMENTS _____

PLEASE INDICATE ANY CONCERNS OR DIFFICULTIES

_____ Frequent colds _____ Vision difficulties _____ Easily angered

_____ Frequent sore throat _____ Hearing difficulties _____ Worries a lot

_____ Frequent ear infection _____ Speech difficulties _____ Tantrums

_____ Running ears/earaches _____ Frequent urination _____ Many fears

_____ Nosebleeds _____ Behavioral concerns _____ Shyness

_____ Toothaches _____ Sleeping problems _____ Excitable

_____ Pain in legs/joints _____ Eating problems _____ Bed wetting

COMMENTS _____

Has your child attended nursery school or day care previously? _____ Yes _____ No

If yes, please describe the type of program _____

How did your child respond to the program? _____

Part II. PHYSICIAN'S REPORT

IMMUNIZATIONS:

	#1	#2	#3	#4	#5
POLIO					
DPT					
MEASLES, MUMPS, RUBELLA					
HIB MENINGITIS (Haemophilus B)					
HEPATITIS B					
VARICELLA (Chickenpox)					
TB SKIN TEST	Date Given	Date Read	Result		

No TB SKIN TEST needed Check here if child is **NOT** at risk for TB and does not need this test.

Significant family history _____

Overall physical and social development _____

EXAMINATION

General Appearance:

Skin _____ Ht. _____ Wt. _____
 EENT: _____ Vision: _____ R. _____
 _____ L. _____

Chest: _____
 Abdomen: _____
 Genitalia: _____ Hearing: _____ R. _____
 _____ L. _____

Extremities: _____
 Neurological: _____
 Other (include laboratory findings): _____ Teeth: _____

TREATMENT OR MEDICATION NOW BEING GIVEN _____

SHOULD THIS CHILD BE RESTRICTED FROM ANY ONGOING DAY CARE ACTIVITIES? _____

Physician's Name (please print) _____ Date _____

Physician's Signature _____

Address _____ Phone _____