



To be completed by the parent / guardian:

Date of Last Physical Exam: _____ Examined By: _____

Name of Primary Care Provider: _____

Address and Phone Number: _____

Name of primary pharmacy: _____ Location: _____

Name / Address / Phone number of Dentist: _____

Date of Last Exam: _____ Unresolved Issues: _____

Your Child's Gender: _____ Your Child's Ethnicity / Race: _____

1. Does your child have any birth defects, handicaps, or chronic illnesses? Yes No If yes, explain:

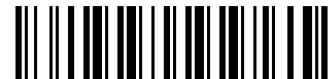
2. Were there any issues with pregnancy? Yes No If yes, explain:

3. Was your child exposed to any prescription drugs, non prescription drugs, or alcohol during pregnancy?
 Yes No If yes, explain:

4. Did your child have any issues sitting, standing, walking, or toilet training? Yes No If yes, explain:

5. Has your child had trouble with hay fever, eczema, or asthma? Yes No If yes, explain:

6. Does your child have allergies? (Include medication, food, seasonal, animal etc. Yes No If yes, explain including reaction:



7. Has your child had all the required immunizations? Yes No
 Date of Last Tetanus _____ Last MMR _____ Last Chicken Pox _____
8. Has your child received an influenza vaccine this season? (Season normally runs Sept/Oct to March/April)
 Yes No If yes, when? _____
 If no, do you consent to patient being given this season's influenza vaccine during this hospitalization if they meet criteria? (Please see attached VIS for more information about the immunization.) Yes No

Parent/Guardian/Legal Custodian Signature: _____

9. Did your child receive the influenza vaccination last flu season? Yes No
10. Has your child ever been knocked out or had a concussion? Yes No If yes, explain:

11. Has your child ever had a heart murmur or heart trouble? Yes No If yes, explain:

12. Has your child ever had a history of urination or kidney problems? Yes No If yes, explain:

13. Has your child ever had a history of stooling or bowel problems? Yes No If yes, explain:

14. Has your child had any persistent or unusual skin rashes? Yes No If yes, explain:

15. Has your child ever had a seizure or convulsion? Yes No If yes, explain:

16. Has your child ever been hospitalized? Yes No If yes, explain:

17. Has your child had any surgeries? Yes No If yes, explain:



18. Is your child presently or recently taking any medication or pills? Yes No
If yes, explain: (Please include prescription, over-the-counter, inhalers, topical, and / or herbal)

Medication	Dose	Time taken	Last dose	Prescribed by
<i>Example: Prozac</i>	<i>20 mg</i>	<i>Every night</i>	<i>Last night</i>	<i>Dr. John</i>
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

19. Has your child ever had any high blood pressure? Yes No If yes, explain:

20. Has anyone in your family died of heart problems or sudden death before the age of 50?
 Yes No If yes, explain:

21. Has your child had any of the medical problems such as: (Please check all that apply)
 Mononucleosis Tuberculosis Diabetes Hepatitis Herpes
 Chicken Pox HIV/AIDS Sexually Transmitted Diseases
 Current Communicable Diseases (i.e. Pneumonia) _____
 MRSA VRE Other: _____

22. Has your child had any recent issues with any of the following in the last six months: (Please check all that apply)
 Lice Scabies Ringworm Impetigo

23. Sleep pattern: What time does your child normally go to sleep _____ Wake up _____
 Explain any issues with sleep: _____

24. Dietary: Does your child have any dietary aversions Yes No
 If yes, explain: _____

25. Does your child have any sensory areas that staff should be aware of: _____

Signature of the person completing form _____

Date _____

