

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

Has the child ever had any problems with the following, if yes, please explain:		
Eyes/Vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Digestion/Nutrition	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Ears/Hearing	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Urine/Kidneys	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Skin	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Lungs	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Teeth	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Heart	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Repeated Infections	<input type="checkbox"/> No <input type="checkbox"/> Yes	

FAMILY HISTORY

Have any of the child's brothers or sisters died? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give age and cause:		
Have any of the child's blood relatives had the following diseases? If yes, please list family member.		
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Allergies/Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Mental/Emotional Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sickle Cell	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes	

DEVELOPMENT

Do you have any concerns about the following? If yes, please explain.		
Development	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Behavior	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Eating Habits	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Sleeping Habits	<input type="checkbox"/> No <input type="checkbox"/> Yes	
School Experiences	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Bathroom/Toilet Habits	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Discipline	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other(explain)	<input type="checkbox"/> No <input type="checkbox"/> Yes	

IMMUNIZATIONS

Up-to-date?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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Parent/Legal Guardian

Date

Reviewed By

Date