

Health History

Name _____

Address _____

Phone # _____ Date of Birth _____

General Health Condition, good? _____

History of:

- | | | |
|--|--|--|
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Ear trouble |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Asthma or Hay |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Hernia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Poison Ivy, Poison Oak, or Poison Sumac | |
| <input type="checkbox"/> Sleep Walks | <input type="checkbox"/> Upsets Easily | <input type="checkbox"/> Other: |

Explain: _____

Disease, injury, recent surgery: _____

Allergies: _____

Medications: _____

Activity Restrictions: _____

Family Doctor's Name _____

Hospital Preference _____

Signature _____ Date _____
(Parent or Guardian)