

**Medical History Form – New Student Registration**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**1. Your Child**

**a. Pregnancy & Birth**

Birth Weight: \_\_\_\_\_ Full-Term      Premature

Describe any problems during pregnancy and/or birth: \_\_\_\_\_

**b. Developmental Milestones**

Age for Walking: \_\_\_\_\_ Talking: \_\_\_\_\_ Toileting: \_\_\_\_\_

Describe eating habits: \_\_\_\_\_

Describe sleeping habits: \_\_\_\_\_

Describe difficulties during preschool years: \_\_\_\_\_

**c. Physical – Has/Does your child have any of the following? (Indicate Yes or No Below. If yes, explain in further comments.)**

**Hospitalizations**

Operations	Yes	No	Joint Pain, Swelling, Limping	Yes	No
Illness	Yes	No	Muscular/Skeletal/Accident Prone	Yes	No
Allergies	Yes	No	Frequent Sore Throats	Yes	No
To: _____			Skin Problems/Concerns	Yes	No
Allergic Reactions	Yes	No	Speech Problems/Concerns	Yes	No
Medications	Yes	No	Seizures	Yes	No
Foods	Yes	No	Medications	Yes	No
Other _____	Yes	No	Vision		
Asthma	Yes	No	Problems/Concerns	Yes	No
On Medication	Yes	No	Sees an Eye Doctor	Yes	No
Bronchitis	Yes	No	Wears Glasses/Contacts	Yes	No
Pneumonia	Yes	No	Worms/Parasites	Yes	No
Finger/Thumb Sucking	Yes	No	Ever Passed Out/Unconscious	Yes	No
Frequent Colds	Yes	No	Prone to Nosebleeds	Yes	No
Coordination Concerns	Yes	No	Tires Easily	Yes	No
Bleeds Easily/Excessive	Yes	No	Developmental Disabilities	Yes	No
Dental Problems	Yes	No	Takes Medication Daily	Yes	No
Elimination			Medication Name _____		
Bed Wetting	Yes	No			
Constipation	Yes	No			
Diarrhea	Yes	No			
Daytime Incontinence	Yes	No			
Wears Pullups	Yes	No			
Endocrine/Diabetes	Yes	No			
Frequent Earaches	Yes	No <sup>1</sup>			
Hearing Loss	Yes	No			
Ear Tubes	Yes	No			
Emotional Concerns	Yes	No			
Headaches	Yes	No			

Further Comments: \_\_\_\_\_

**d. Inner Self**

Excessive Shyness	Yes	No
Temper Tantrums	Yes	No
Persistent Crying	Yes	No
Nail Biting	Yes	No
Social with Peers	Yes	No

2. Your Family

a. Family Members

<u>Relationship</u>	<u>Birthdate</u>	<u>Name</u>
Mother	XXXXXXX	_____
Father	XXXXXXX	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Medical History (Indicate Yes or No if immediate family members have history, as listed below)

Sudden Cardiac Death	Yes	No	Heart Disease	Yes	No
Allergies	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Development Disability	Yes	No
Bleeding Disorders	Yes	No	Mental Health Illness	Yes	No
Vision Disorder	Yes	No	Lead Poisoning	Yes	No
Cancer	Yes	No	Seizures	Yes	No
Hearing Disorder	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Kidney Disease	Yes	No
Drug/Alcohol Addiction	Yes	No			

Please note the relative for any Yes, above: \_\_\_\_\_

Further Comments/Information

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_