HEALTH HISTORY FORM

NAME: **DATE OF BIRTH**:

PARENT/GUARDIAN: _____

ALLERGIES: _____

SOCIAL HISTORY:

Lives with: _____

Grade in School: _____

Smoking in the home: YES/NO

Immunizations Up to Date: YES/NO

FAMILY MEDICAL HISTORY:

Mother:

Father:

Siblings:

Grandparents:

SURGICAL HISTORY:

PROCEDURE	DATE

HOSPITALIZATIONS:

REASON:	DATE(s):

MEDICATIONS:

NAME:	DOSE:	FREQUENCY:

LIST OF SPECIALISTS:

DOCTOR	SPECIALITY	REASON	PHONE #	LAST APPT	NEXT APPT