CHILD'S HEALTH HISTORY CHECKLIST

CHILD'S NAME_____ **DOB**_____

PARENT OR GUARDIAN'S NAME_____

Does your child take any medications on a regular basis? _____
If yes, please list medication and side effects:
_____
_____

Has your child ever been hospitalized? _____
If yes, please explain:
_____
_____

Does your child use a sippy cup? _____
Does your child wet the bed? _____
Does your child have asthma? _____
Does your child wheeze on a regular basis? _____
Does your child have a speech problem? _____
Does your child have a hearing problem? _____
Does your child wear glasses or need them? _____
Has your child had more than two ear infections in a year? _____
Has your child had their tonsils removed? _____
Is your child epileptic or do they have seizures? _____
Does your child have a heart murmur? _____
Has your child ever had worms? _____
Is your child a hemophiliac (free bleeder)? _____
Does your child have tubes in their ears? _____
Does your child have bladder problems? _____
Does your child have any problems having bowel movements? _____
Does your child have sinus problems? _____

Please list any other information you feel may be important:
_____
_____
_____