Child’s First Name  Last Name  Date of Birth

Does your child take any medications?  ____ Yes  ____ No  If yes, please list:

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Strength</th>
<th>Frequency Taken</th>
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Does your child have allergies?  Yes   No   If yes, please list along with reaction:

________________________________________________________

Does or did your child have any of these problems now or in the past? Please circle.

- Asthma
- Birth Problems
- Blood Clots/Stroke
- Cancer
- Chicken Pox
- Pins/Broken Bones
- Seizures

Asthma   Heart Disease   Migraines
Birth Problems   High Blood Pressure   Diabetes
Blood Clots/Stroke   Development/Learning Delays   ADHD
Cancer   Behavioral-Mental Illness   Depression
Chicken Pox   Sickle Cell Anemia   Heart Murmur
Pins/Broken Bones   Eating Disorder   Drug/Alcohol Abuse
Seizures   Tobaccos Use   Stomach/GI Disorder

Other:

________________________________________________________

Has your child been hospitalized overnight or had surgery or any serious injuries?  If yes, please list:

________________________________________________________

Does anyone in your family (parents, siblings, grandparents, aunts/uncles) have any of these problems, now or in the past?

- Asthma
- Blood Clots/Stroke
- Cancer
- Diabetes
- Drug/Alcohol Abuse
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Mental Illness/Depression
- Sickle Cell Anemia
- Tuberculosis/TB

Asthma……………………………………..if yes, who? 
Blood Clots/Stroke…………………….if yes, who? 
Cancer…………………………………..if yes, who? 
Diabetes………………………………..if yes, who? 
Drug/Alcohol Abuse……………………..if yes, who? 
Heart Disease…………………………if yes, who? 
High Blood Pressure……………………if yes, who? 
High Cholesterol………………………if yes, who? 
Mental Illness/Depression………………..if yes, who? 
Sickle Cell Anemia……………………..if yes, who? 
Tuberculosis/TB………………………..if yes, who?

How many days of the week does your child engage in physical exercise _________________

Is the child currently pregnant  ____ No  ____ Yes