

LIFECHANGE - MEDICAL HISTORY FORM

To be filled out by parent

Child's Name: _____ Age: _____ Date of Birth: _____

Does your child have or have they experienced the following: *(Check all that apply)*

<input type="checkbox"/>	Dizziness or fainting spells	<input type="checkbox"/>	Frequent or migraine headaches
<input type="checkbox"/>	Skin allergies or rashes	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Warts or sores	<input type="checkbox"/>	Thyroid conditions or disease
<input type="checkbox"/>	Chest pain or shortness of breath	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Frequent stomachaches/indigestion	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	Frequent urinary infections	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Unexplained weight change	<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	Difficulty walking, running or lifting	<input type="checkbox"/>	Gall stones
<input type="checkbox"/>	Mumps, measles	<input type="checkbox"/>	Chicken Pox
<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	Heavy periods	<input type="checkbox"/>	Periods longer than 8 days
<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	Abortion or miscarriage

Does your child have any physical limitations? _____ If yes, please explain: _____

Is your child allergic to any medications, food, plants, animals, etc.? If yes, please list:

Has your mother, father, brother, sister or children had any of the following:

Diabetes _____ Depression _____ High Blood Pressure _____

Tuberculosis _____ Heart Disease _____ Emotional Disorders _____

Mental Disorders _____ Cancer _____ Blood Disease _____

Child's Personal Information

Height		Speech Impairment?	
Hair Color		Orthodontic Braces?	
Weight		Glasses/Contacts?	
Eye Color		Hearing Impairment?	
Blood Type			

Please attach a copy of your child's insurance/medical card and any written prescriptions.