

Health History

Check – Give approximate dates

_____ Frequent Ear Infections	Date/s: _____
_____ Heart Defect/Disease	Date/s: _____
_____ Convulsions	Date/s: _____
_____ Diabetes	Date/s: _____
_____ Bleeding/Clotting disorders	Date/s: _____
_____ Hypertension	Date/s: _____
_____ Mononucleosis	Date/s: _____

Has this person required any psychiatric counseling or hospitalization? _____

Operations or Serious Injuries (w/Dates): _____

Disability or Chronic recurring illness: _____

Activities encouraged or limited by physician: _____

Other diseases and details from above: _____

Name of Dentist: _____

Phone: _____

Name of Family Physician: _____

Phone: _____

Date of last physical examination: _____

Do you carry family medical/health insurance: YES NO

If so, please indicate: Carrier: _____

Policy#: _____

For Females:

Has this person menstruated? _____ Is cycle normal? _____ If not, has she been told about it? _____

Special consideration: _____

Immunization History

Vaccines	Year of Basic Immunization	Year of Last Booster
DPT: Diphtheria	1	1
Pertussis (Whooping Cough)	2	2
Tetanus	3	
TD: Tetanus		
Diphtheria		
Oral Polio (Sabin TOPV)		
Injectable Polio (Salk)		
MMR: Measles, Mumps, Rubella		
Tuberculin Test (most recent date)		
Haemophilus Influenza (HIB)		
Hepatitis B		
Varicella: Chicken Pox		
Other:		

Reverse Side of Form MUST be Completed