JCYS LUTZ FAMILY CENTER

HEALTH HISTORY

To be completed by Parent/Guardian of : ____ (child's name)

(Circle Yes or No)			**Comments**
Chicken Pox	Yes	No	________________
Dental	Yes	No	________________
TB/TB Contact	Yes	No	________________
Birth Defects	Yes	No	________________
Blood Disorders:			
Hemophilia	Yes	No	________________
Sickle Cell	Yes	No	________________
Other	Yes	No	________________
Diabetes	Yes	No	________________
Seizures	Yes	No	________________
Heart Problems	Yes	No	________________
Ear / Hearing Problems	Yes	No	________________
Ear Infections	Yes	No	________________
Speech Problems	Yes	No	________________
Eye / Vision Problems	Yes	No	________________
Serious Injuries	Yes	No	________________
Bone / Joint Problems	Yes	No	________________
Asthma	Yes	No	________________
Surgery	Yes	No	________________

Date ______________ Reason ____

Hospitalization Yes No ________________

Date ______________ Reason ____

Developmental Delay Yes No ________________

Allergies (list) ____

Medications (list) ____

Other Concerns ____

____ ________________

Parent/Guardian Signature Date