Chart#_____

East Valley Children's Center

Personal History Data Base for Children > age 5

_____ _____

Child's Full Name Birth Date

Current Grade _____

Prior Physician(s) _____

_____

Medication Allergies:

_____

_____

Chronic Illnesses:

_____

_____

☐Hospitalization_____

☐Surgery_____

☐Serious Injury_____

☐Serious reaction to Immunization_____

Chronic Medications (List):

_____

_____

Has your child had any of the following:

☐More than three ear infections
☐Hearing loss
☐Eye or vision problems
☐Asthma/recurring bronchitis
☐Pneumonia
☐Heart murmur or heart problems
☐Bladder or Urine infections
☐Chronic Bowel Problems
☐Eczema or chronic skin condition
☐Allergies or hayfever
☐Seizures with fever
☐Seizures without fever
☐Cerebral Palsy
☐Developmental Delay
☐Bed wetting
☐School Problems_____

_____

☐Significant behavior problems_____

☐Other Problems_____

_____

_____

If you have a pool, is it fenced ☐Y ☐N
Do you have smoke alarms ☐Y ☐N
Does anyone smoke in the home ☐Y ☐N
Do you know the hot water temperature ☐Y ☐N
Do you use seatbelts ☐Y ☐N
Any guns in the home ☐Y ☐N
Uses a bicycle helmet ☐Y ☐N

Immunizations:
Current/Up to date ☐Y ☐N
Please provide a copy of immunization history
Sports/Hobbies _____

_____

>2 Hours/Day on Computer ☐Y ☐N
>2 hours/Day watching TV ☐Y ☐N

Hours per day of exercise/physical activity _____

Please describe his/her health, attitude and behavior

_____

_____