**GENERAL HEALTH HISTORY**

Physician _____

Address _____

Street city state zip

Phone _____

Specialists _____

Are immunizations up to date? Yes ____ No_____

Does your child take any medications on a regular basis? Yes___ No _____

If so, please describe _____

Medical diagnosis _____

As far as you know, has your child had difficulty with any of the following:

| | | | | |
|---|---|---|---|---|
| Allergies__ | heart__ | eczema__ | stomach or bowel__ | anemia__ |
| feeding__ | asthma__ | vision__ | frequent fevers__ | hearing__ |
| ear infections__ | ear tubes__ | meningitis__ | seizures__ | sleeping__ |