Name ____

Allergies

Does your child have any allergies or sensitivities to drugs or dressings? (Please circle)

NO	**YES** (please specify)

Medical Conditions (Past and present)

Operations (Please include the year)

Medications (Current medications including over the counter medications & supplements)

Medication	Strength	How many per day

Family Medical History (e.g. Eczema, asthma, cancer, heart disease, diabetes etc.)

Birth History

Was your child born at full term (38 + weeks):
Any complications during pregnancy or birth:

Vaccinations

Has your child had the following vaccinations? (please circle)

Birth (hep B)	**Yes / No**	12 months	**Yes / No**
2 months	**Yes / No**	18 months	**Yes / No**
4 months	**Yes / No**	4 years	**Yes / No**
6 months	**Yes / No**	Other?	**Yes / No**

Social

How many siblings:

Does your child attend daycare or school (which grade):

Has your child had any delay in development? Any hearing or vision problems?