



Cardinal Cushing Centers

MEDICAL HISTORY

NAME _____ DOB _____

F M L

Names of all doctors, neighborhood health centers, clinics, etc. where child currently receives care: _____

MASS HEALTH: _____ POLICY # _____ / _____

INS. CO.: _____ POLICY # _____

FAMILY HISTORY:

- 1. Father's name: _____ Age _____
State of father's health: _____
Mother's name: _____ Age _____
State of mother's health: _____

Brothers and Sisters	<u>Age</u>	<u>Sex</u>	<u>State of Health</u>
First Name: _____			

- 2. If any members of the immediate family or the child's grandparents have died, give the relationship of the deceased to the child and the cause of death (or details about the illness if the cause of death is unknown: _____

- 3. Does anyone in the family have: _____ What relationship to child?

- | | | | |
|----------------------|-----------|----------|-------|
| Diabetes? | _____ Yes | _____ No | _____ |
| Allergies or Asthma? | _____ Yes | _____ No | _____ |
| Heart Disease? | _____ Yes | _____ No | _____ |
| Kidney Disease? | _____ Yes | _____ No | _____ |
| Hypertension? | _____ Yes | _____ No | _____ |

Is there any other disease which "runs in the family"? _____ Yes _____ No
If so, give details: _____

CHILD'S MEDICAL HISTORY:

- 1. Mother's pregnancy:
 - a. Was baby premature? _____ Yes _____ No
 - b. Were there any complications? _____ Yes _____ No. If yes, please explain: _____

 - c. Did mother take any medicine other than iron or vitamins while pregnant? _____ Yes _____ No
If yes, what kind of medicine was taken and when during the pregnancy? _____

- 2. Birth:
 - a. In what hospital was the child born? _____
 - b. Was the child delivered by Cesarean Section? ____ Yes ____ No
 - c. What was the child's weight at birth? _____
 - d. Did the baby have any problems while in the hospital, with feeding, breathing, infections, etc.?
 ____ Yes ____ No If "yes", explain:

ACUTE INFECTIONS:

- 1. Has the child had:

Measles	____ Yes	____ No
German Measles	____ Yes	____ No
Mumps	____ Yes	____ No
Chicken Pox	____ Yes	____ No
Rheumatic Fever	____ Yes	____ No
- 2. Were there any complications from any of these diseases?
 ____ Yes ____ No If "yes", explain: _____

IMMUNIZATIONS:

REQUIRED

- 1. Has the child had the following immunizations:

			<u>Series</u>	<u>Date of last</u>
			<u>Dates</u>	<u>booster</u>
DPT (Diphtheria, pertussus, tetanus)?	____ Yes	____ No	_____	_____
Polio?	____ Yes	____ No	_____	_____
Smallpox?	____ Yes	____ No	_____	_____
MMR (Measles, Mumps, Rubella)				
(Need 2 shots for Measles)?	____ Yes	____ No	_____	_____
Other _____	____ Yes	____ No	_____	_____
- 2. When did the child have his/her last Tuberculin Test? _____

ALLERGIES:

- 1. Is the child allergic to any food/drug? ____ Yes ____ No If "yes", what is he/she allergic to?

- 2. What is the allergic reaction (Hives, Asthma, etc.)? _____
- 3. Does the child have any contact allergies to wool, clothing, adhesive tape, etc. (in contact with skin)?
 ____ Yes ____ No If "yes", what is he/she allergic to? _____

INJURIES AND OPERATIONS:

- 1. Has the child ever suffered a major injury which required hospitalization? ____ Yes ____ No
 If "yes", give details: _____

- 2. Has child ever had an operation (including Tonsillectomy or Hernia repair)? ____ Yes ____ No
 If "yes", give date and details: _____

CHRONIC CONDITIONS:

Does child have any condition for which he/she is under a physician's care or for which he/she takes medication? ____ Yes ____ No If "yes", give details: _____
