Medical Information Intake Form – Ages 3-14 years

Name: _____ Birth Date: _____

****PLEASE ATTACH CURRENT IMMUNIZATION RECORD****

Parents' Marital Status: _____ Lives with: _____

____ Brothers _____Sisters Birth Order: _____

School: _____ Grade: _____ Level of work: (Circle one) Below At Above

Sports: _____

Hobbies: _____

Medical Problems/Significant Hospital Stays	Year	Previous Surgeries	Year
1. _____	____	1. _____	_____
2. _____	____	2. _____	_____
3. _____	____	3. _____	_____

Family Medical History (i.e. heart attack, stroke, diabetes, colon cancer)

Mother: _____ Father: _____

Sibling(s): _____

Other: _____

Medications:

Name	Strength	Directions as noted on bottle
1.		
2.		
3.		
4.		
5.		

Allergies to medication	reaction
1. _____	_____
2. _____	_____
3. _____	_____