ST. MARY OUR MOTHER SCHOOL
STUDENT MEDICAL HISTORY

Student Name____ DOB ______________ Entering grade______
Please provide:
Physician's Name_______________________________ Physician's Phone ______________________________
Dentist's Name________________________________ Eye Specialist _________________________________
Preferred hospital____

Please indicate below any difficulties during pregnancy, labor, delivery, or shortly after birth.

Were developmental milestones, such as walking, talking, toilet training, etc. considered within normal limits?
Yes___________ No___________ If no, please explain

Is there any history of the following: (Yes or No)

1. **Serious illness ______**
2. **Hospitalization ______**
3. **Accident or broken bones _____**
4. **Seizures, if yes, date of last seizure _________________________**
5. **Convulsions, kidney disease ______**
6. **Head injury ______**
7. **Vision or hearing problems ______**

Check if child has had:

Strep Throat	______	**Scarlet Fever**	______
Epilepsy	______	**Diabetes**	______
Rheumatic Fever	______	**Asthma**	______
Chickenpox	______	**Heart Disease/Murmur**	______

Has your child ever had any serious accidents, operations or hospitalizations? (Specify)
____

Allergies (Specify) ____
____

Does your child have a history of frequent ear infections? _______________________________________

Other medical conditions? (Specify) ____

When was the child's last complete physical? ____
Any recommendations from the physician?
____

Is the child presently on any medication: If so, what?____

____

Has the child been on medication in the past? If so, what?_______________________________________

Does your child need/use glasses? Yes______ No ______ Contact lenses? Yes ______No ______

Does your child have dental braces?_______ If so, name of orthodontist?__________________________