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PERSONAL AND FAMILY HEALTH HISTORY (to be completed by parent/guardian)

Child's Name _____ Nickname _____ Date of Birth _____

Birth History:

Mother's Illness During Pregnancy _____ Birth Weight _____
Delivery Complications _____ Full Term _____ or Premature _____

Family History: Please indicate if any family member has had the following and their relationship to child.

Allergies _____ Heart Disease _____
Cancer _____ Diabetes _____
Learning Problems _____ High Blood Pressure _____

Student History:

1. How do you feel your child's health is now? _____

2. Does your child have any allergies (meds/foods/environment)? Yes _____ No _____

3. Does your child take medication regularly? Yes ___ No ___ Reason for med _____

4. Has your child had any serious illness, accidents or operations? Yes _____ No _____
If yes, describe and give dates. _____

5. Does your child have frequent colds? Yes _____ No _____ How often? _____

6. Has your child ever had the following? Please give month and year if known.

Asthma _____ Mononucleosis _____
Bronchitis _____ Kidney Disease _____
Pneumonia _____ Learning Difficulties _____
Nosebleeds _____ Ear Infections _____
Heart problems _____ Scarlet Fever _____
ADD/ADHD _____ Rashes _____
Strep Throat _____ Emotional Difficulties _____
Chicken Pox _____ Tonsillitis _____

7. Does your child have any difficulty with: Vision _____ Wear glasses/lenses _____
Hearing _____ Requires Hearing Aid _____ Speech _____

8. Does your child see a doctor, dentist, counselor for other than yearly exam? _____
If yes, for what conditions and how often? _____

9. Please describe if your child experienced emotional stress or shock? (i.e., death, divorce, accident, etc.)

10. Additional comments or concerns: _____

Parent signature _____ Date _____