

ConnextCare <u>Child</u> Health History Form

DOB: Sex: M F MEDICAL HISTORY: Birth Wt: Length: Place of Birth: Does the child have any serious medical problems? If yes please list: Does the child have any serious medical problems? If yes please list: FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: DATE: CONDITION/SURGERY: NONE: DATE:	Name:			Date:	
Birth Wt.: Length: Does the child have any serious medical problems? If yes please list: FAMILY HISTORY: Any family history of serious illnesses such as diabetes, high blood pressure, heart disease, cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:	DOB:	Sex:	М	F	
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cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:	Does the child have any serious medical problems? If yes please list:				
cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:					
cancer, or tuberculosis: HOSPITALIZATIONS/SURGERY: NONE:					
HOSPITALIZATIONS/SURGERY: NONE:					
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DATE: CONDITION/SURGERY:	HOSPITALIZATIONS/SURGERY: NO		NONE:		
	DATE:	CONDITION/SURGERY:			
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SOCIAL HISTORY:					
Number of Adults at Home: Number of Children at Home:					
Any Smokers Living in the Home?					
Current School:					
Does the child have records at an additional Physician/Pediatrician's office? Yes / No					
If yes please list name and address:					