Tuolumne Me-Wuk Indian Health Center

Your Child's Medical History

HRN: _____

Date: _____

Your child's Name: _____ Birth Date: _____

Your Child's Physician Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Is your child taking any medications? (Circle one of the following) Yes No

If yes, please list _____

Does your child have any allergic (or adverse) reaction to any medication(s)? Yes No

If yes, please list_____

Are your child's immunization current? Yes No ***PLEASE BRING THE IMMUNIZATION CARD TO VISIT**

List any Hospitalizations, Surgeries, Serious Illnesses When?

_____ _____

_____ _____

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

AIDS/HIV Positive	○ Yes ○ No	Behavioral or Learning Disorders	○ Yes ○ No	Measles/Mumps	○ Yes ○ No
Allergies or Hives	○ Yes ○ No	Rheumatic/Scarlet Fever	○ Yes ○ No	Mononucleosis	○ Yes ○ No
Anemia	○ Yes ○ No	Congenital Heart Disease	○ Yes ○ No	Nervous Disorders	○ Yes ○ No
Asthma	○ Yes ○ No	Handicaps/Disabilities	○ Yes ○ No	Bleeding Disorder	○ Yes ○ No
Diabetes	○ Yes ○ No	Heart Condition	○ Yes ○ No	Hearing Problem	○ Yes ○ No
Brain Injury	○ Yes ○ No	Cerebral Palsy	○ Yes ○ No	Chicken Pox	○ Yes ○ No
Cancer	○ Yes ○ No	Kidney/Liver Problem	○ Yes ○ No	Latex Sensitivity	○ Yes ○ No
Hepatitis A B or C	○ Yes ○ No	Sickle Cell Anemia	○ Yes ○ No	Stomach Problem	○ Yes ○ No
Epilepsy	○ Yes ○ No	Tuberculosis (TB)	○ Yes ○ No	Urinary Problem	○ Yes ○ No
Hay Fever	○ Yes ○ No	Lung Problem	○ Yes ○ No		

Other? Yes ____ No ____ Please specify _____

I understand that the above information is necessary to provide my child with medical care in a safe and efficient manner. Should further information be needed, I will complete a Release of Record to request health care records from my child's previous Medical Provider.

Signature of Parent/Legal Guardian_____ Date: _____