



CHILD MEDICAL HISTORY FORM

Missions Ministry Team

Date _____

Name _____

Home Phone _____

Address _____

Mobile Phone _____

City _____

State _____

Zip _____

Date of Birth _____

___ M ___ F

Weight _____

Parent/Guardian _____

Phone _____

Next closest relative _____

Phone _____

Medical Insurance Information

Name of Medical Insurance Company _____

Phone _____

Medical Insurance ID Number _____

Group Number _____

Name of Policy Holder _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical exam was on _____. | | |
| 4. Are you currently under the care of a physician?
If so, what is the condition being treated? _____ | Yes | No |
| 5. The name and address of my physician is: _____ | | |
| 6. Have you had any serious illness, operation, or hospitalization in the last 5 years?
If so, what was the problem? _____ | Yes | No |
| 7. Are you taking any prescription or non-prescription medications?
If so, what are you taking? _____ | Yes | No |
| 8. Do you currently have, or have you had in the past, any of the following diseases or problems? | | |
| a. Damaged heart valves or artificial heart valves, including heart murmur or
rheumatic heart disease? | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency,
coronary occlusion, high blood pressure, arteriosclerosis, stroke)? | Yes | No |
| 1. Do you have chest pain upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise or when lying down? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you have inborn heart defects? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |

c. Allergies?	Yes	No
d. Sinus trouble?	Yes	No
e. Asthma or hay fever?	Yes	No
f. Fainting spells or seizures?	Yes	No
g. Persistent diarrhea or recent weight loss?	Yes	No
h. Diabetes?	Yes	No
i. Hepatitis, jaundice, or liver disease?	Yes	No
j. AIDS or HIV infection?	Yes	No
k. Thyroid problems?	Yes	No
l. Respiratory problems, emphysema, bronchitis, etc.?	Yes	No
m. Arthritis or painful, swollen joints?	Yes	No
n. Stomach ulcer or hyperactivity?	Yes	No
o. Kidney trouble?	Yes	No
p. Tuberculosis?	Yes	No
q. Persistent cough or cough that produces blood?	Yes	No
r. Persistent swollen glands in neck?	Yes	No
s. Low blood pressure?	Yes	No
t. Sexually transmitted disease?	Yes	No
u. Epilepsy or other neurological disease?	Yes	No
v. Problems with mental health?	Yes	No
w. Cancer?	Yes	No
x. Problems of the immune system?	Yes	No
9. Have you had abnormal bleeding?	Yes	No
a. Have you ever required a blood transfusion?	Yes	No
10. Do you have any blood disorder such as anemia?	Yes	No
11. Have you ever had any treatment for a tumor or growth?	Yes	No
12. Are you allergic or have you had a reaction to:		
a. Local anesthetics?	Yes	No
b. Penicillin or other antibiotics?	Yes	No
c. Sulfa drugs?	Yes	No
d. Barbiturates, sedatives, or sleeping pills?	Yes	No
e. Aspirin?	Yes	No
f. Iodine?	Yes	No
g. Codeine or other narcotics?	Yes	No
h. Other _____		
13. Do you have any disease, condition, or problem not listed above that you think should be mentioned? Yes	Yes	No
If so, explain _____		
14. Do you wear contact lenses?	Yes	No
15. Do you wear removable dental appliances?	Yes	No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold the Northwest Chapel staff responsible for any errors or omissions that I may have made in the completion of this form.

PARENT SIGNATURE