Alphabet Soup Preschool
Health History

Child's Name:_____ Birth Date:_____

Last Physical Examination:_____

Child's Doctor:_____

Child's Dentist:_____

Has your child experienced any of the following? (please circle)

constipation	convulsions	frequent diarrhea	fainting
frequent colds	ear infections	frequent sore throat	lice
ringworm	skin rash	upset stomach	worms
urinary problems	asthma	bronchitis	diabetes
chicken pox	heart disease	hepatitis	impetigo
German measles	measles	scarlet fever	polio
tuberculosis	whooping cough		

Other illnesses or health concerns not listed above?

_____

_____

_____

Has your child been hospitalized? (explain)

_____

_____

Has your child had injuries or loss of consciousness? (explain)

_____

_____

Please attach a copy of your child's updated immunization records.