OFFICE OF HEALTH STATUS MONITORING
DEPARTMENT OF HEALTH

Legal Name of Child:
Birthdate:
Sex/Race:

Worker/Title:
Phone No.:
Date:

MEDICAL INFORMATION FORM
FAMILY OF: [ ] CHILD'S MOTHER [ ]CHILD'S FATHER

NAME _____ ADDRESS
(Only on Original) (Only on Original)

BIRTHDATE _____ RACE _____ RELIGION
MARITAL STATUS: (at birth of child)
[ ] Married [ ] Separated [ ] Divorced [ ]Widowed [ ] Single

FOR MOTHER OF CHILD, DESCRIBE VERIFICATIONS, INCLUDING DATES OF DIVORCES OR DEATHS:

	(CHILD'S) PARENT	(CHILD'S) GRAND-MOTHER	(CHILD'S) GRAND-FATHER	CHILD'S SIBLINGS OR (PARENT'S BROTHERS/SISTERS) SPECIFY		
YEAR OF BIRTH						
HAIR COLOR						
EYE COLOR						
COMPLEXION						
WEIGHT						
HEIGHT						
EDUCATION						
EMPLOYMENT (include military)						
HOBBIES, INTERESTS, TALENTS						

ADDITIONAL INFORMATION: (Include special characteristics of parent or of relatives, including evaluation of social functioning and general intelligence)

Source of Information:

MEDICAL CONDITION	YES (Self)	YES-RELATIVE (Specify)	COMMENTS
A. CONGENITAL IMPAIRMENTS			
1. Club Foot or any orthopedic problem			
2. Harelip (cleft lip) or cleft palate			
3. Chromosome abnormality			
4. Downs Syndrome			
5. Hydrocephalus			
6. Muscular Dystrophy			Parts of body involved? Age at onset?
7. Spina Bifida			
8. Congenital Heart Defect			
9. Tay-Sach's Disease			
B. ALLERGIES			Any cause known? What treatment? What medication?
1. Eczema or other skin condition			
2. Hay fever or other allergy			
3. Drug allergy			To what drugs?
C. EYE, EAR, DEVELOPMENT DISORDERS			
1. Blindness, glaucoma, color blindness or other visual problems			
2. Deafness or other ear problem			Special Education? If "yes" indicate age at onset.
3. Speech problems			
4. Learning disability			Any diagnosis? Hospitalization?
5. Retardation: mental or physical			

MEDICAL CONDITION	YES (Self)	YES-RELATIVE (Specify)	COMMENTS
D. GENERAL DISORDERS 1. Hemophilia			
2. Sickle cell anemia or trait			
3. Hypertension (high blood pressure)			Age at onset? What treatment? Hospitalization?
4. Stroke			
5. Heart attack (coronary)			
6. Arthritis			What kind? Age at onset? What part of body?
7. Kidney disease			Age at onset? What treatment?
E. HORMONAL DISORDERS 1. Diabetes			Age at onset? What treatment?
2. Thyroid disorder			
F. RESPIRATORY DISORDERS 1. Asthma			Any cause known? What treatment?
2. Tuberculosis			What kind? Age at onset? What part of body?
G. MENTAL AND BEHAVIORAL DISORDERS 1. Schizophrenia			Age at onset? What treatment? Hospitalization?
2. Manic depressive			
3. Alcoholism or heavy drinking			
4. Drug use			Kind, amount, and when taken?

MEDICAL CONDITION	YES (Self)	YES-RELATIVE (Specify)	COMMENTS
H. LYMPHATIC DISORDERS 1. Cancer			What kind? Age at onset? What part of body
2. Other tumors			
3. Cystic fibrosis			
4. Hodgkins disease			
I. NERVOUS SYSTEM DISORDERS 1. Multiple sclerosis			Parts of body involved? Age at onset
2. Huntington's disease			
3. Cerebral palsy			
4. Seizures or convulsions			Age at onset? What treatment? Frequency?
5. Epilepsy			
J. INFECTION, HOSPITALIZATION 1. Repeated attacks of fever with known infection			Diagnosis?
2. Repeated severe infection necessitating hospitalization			
3. Hospitalization, operation, or injury			
K. OTHER IMPAIRMENT, ALLERGY DISORDER OR DISEASE			

RESET FORM