MEDICAL HISTORY

Applicants Name _____
(first) (middle) (last)

A. Contact Information (medical)

Physician _____
(Name) (Address) (Phone)
Physician _____
(Name) (Address) (Phone)
Dentist_____
(Name) (Address) (Phone)
Hospital_____
(Name) (Address) (Phone)

Diagnoses_____

Current Medications (name, dosage, reason)_____

_____

B. Family Medical History

Condition	Yes	No	Specify Relative
Alcohol/Drug Abuse			
Cerebral Palsy			
Seizures			
Mental Retardation			
Diabetes			
Deafness/Blindness			
Learning Disability			
Psychiatric Problems			
Cancer			
Heart Disease			
Birth Defects			
Other			

C. Birth History (if available)

Duration of pregnancy_____ **Complications**_____

Prenatal care (Y/N) ___ **Maternal Age** _____ **Fathers Age**_____

Medications during pregnancy _____

Duration of Labor_____ **Complications**_____

Method of Delivery _____ **Birth weight** _____

Complications at birth _____

D. Early Development and Consumer Medical Information

1. **Were developmental milestones achieved on time or delayed?** _____

2. **At what age was disability diagnosed?** _____

2. Childhood Disease

Diseases	yes/no	Age	Diseases	Yes /no	Age
High Fever			Meningitis		
Chicken Pox			Scarlet Fever		
Measles			Rheumatic Fever		
German Measles (rubella)			Encephalitis		
Mumps			Other		

3. Physical Condition

Physical Condition	Yes/No	Current	Past	Comments
Colds/Infections				
Ear Infections				
Pneumonia				
Chronic Cough				
Constipation/Diarrhea				
Bladder/Kidney problems				
Tonsillitis/Strep Throat				
Fractures				
Hearing Problems				
Visual Problems				
Speech Problems				
Eating Disorders				
Sleep Disorders				
Serious Head Injuries				
Other Problems (specify)				

4. Describe major illnesses/hospitalizations _____

_____

5. Allergies (Explain or Specify)
Drugs/immunization reaction _____

_____

Food _____ Other _____

6. Seizures (y/n) _____ Type _____ Frequency _____ Controlled (y/n) _____

Medications_____

Describe Seizures _____

7. Adaptive Equipment (please check all that apply) Glasses ___ Hearing aids ___

Crutches ___ Walker ___ Wheelchair ___ Dentures ___ Corrective Shoes ___ Leg Brace ___

Communication Devices (describe) _____

Date _____ Person completing this form _____