OFFICE OF HEALTH STATUS MONITORING DEPARTMENT OF HEALTH

Legal Name of Ch Birthdate: Sex/Race:	ild:	Worker/Title: Phone No.: Date:				
	FAMILY	_	LINFORMAT D'S MOTHEF	ION FORM R []CHILD'S	FATHER	
NAME	(Only on Orig	inal) Al	DDRESS	(Only on Original)		
	rried [] Se	parated [] [Divorced []	Widowed [] Single G DATES OF D	VIVORCES OR
	(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 social function Source of Info	ing and general		l characteristics	of parent or of re	elatives, including	g evaluation of
_	E 1 OF 4 PAGES				MEDICAL INFO	ORMATION FORM

& RG-AC-508 (12/17) 1F-P-2030

MEDICAL CONDITION	YES (Self)	YES-RELATIVE (Specify)	COMMENTS	
A. CONGENITAL IMPAIRMENTS				
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?	
Eczema or other skin condition			what medication?	
2. Hay fever or other allergy				
3. Drug allergy			To what drugs?	
C. EYE, EAR, DEVELOPMENT DISORDERS				
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			. Onset.	
4. Learning disability			Any diagnosis? Hospitalization?	
5. Retardation: mental or physical				
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MEDICAL CONDITION	YES (Self)	YES-RELATIVE (Specify)	COMMENTS
D. GENERAL DISORDERS1. Hemophilia			
2. Sickle cell anemia or trait			
3. Hypertension (high blood pressure)			Age at onset? What treatment? Hospitalization?
4. Stroke			Hospitalization:
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			Age at onset? What treatment? Hospitalization?
1. Schizophrenia			
2. Manic depressive			
3. Alcoholism or heavy drinking			
4. Drug use			Kind, amount, and when taken?
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08/07/01 PAGE 3 OF 4 PAGES MEDICAL INFORMATION FORM

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			Diagnosis?
 Repeated attacks of fever with known infection 			
Repeated severe infection necessitating hospitalization			
3. Hospitalization, operation, or injury			
K. OTHER IMPAIRMENT, ALLERGY DISORDER OR DISEASE			
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