

**Central Wisconsin Children's Museum Downtown Date Night  
Child Health History Form**

Date: \_\_\_\_\_

Child(ren)'s name: \_\_\_\_\_

Parents' names: \_\_\_\_\_

Child's age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**1. Medical History**

**Medical problems**

- |                      |           |          |
|----------------------|-----------|----------|
| a. Asthma            | _____ Yes | _____ No |
| b. Allergies         | _____ Yes | _____ No |
| c. Eczema            | _____ Yes | _____ No |
| d. Diarrhea          | _____ Yes | _____ No |
| e. Constipation      | _____ Yes | _____ No |
| f. Seizure disorders | _____ Yes | _____ No |
| g. Other             | _____     |          |

**2. Family History**

a. Mother's health: \_\_\_\_\_ Excellent \_\_\_\_\_ Fair \_\_\_\_\_ Poor (please explain below)

\_\_\_\_\_

b. Father's health: : \_\_\_\_\_ Excellent \_\_\_\_\_ Fair \_\_\_\_\_ Poor (please explain below)

\_\_\_\_\_

c. Sibling's health: : \_\_\_\_\_ Excellent \_\_\_\_\_ Fair \_\_\_\_\_ Poor (please explain below)

\_\_\_\_\_

d. Any other significant health problems in family? \_\_\_\_\_ Yes (please explain below) \_\_\_\_\_ No

\_\_\_\_\_

**4. Please describe your child's diet**

a. Allergies: \_\_\_\_\_

\_\_\_\_\_

b. Foods child will not eat: \_\_\_\_\_

**FOR CHILDREN WITH DEVELOPMENTAL DELAYS AND/OR AUTISM-**

Please list any special instructions/considerations for your child: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_