

Name \_\_\_\_\_

New Jersey Department of Health  
HEALTH APPRAISAL RECORD

Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Father \_\_\_\_\_ Mother(Maiden name) \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

PERSONAL HEALTH HISTORY

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

	No	Yes		No	Yes	Date
Illness of mother during pregnancy	___	___	Trouble with Vision	___	___	_____
Birth Weight ___ lbs. ___ oz.			Frequent vomiting/diarrhea	___	___	_____
Complications of delivery	___	___	Tendency to bleed easily	___	___	_____
Difficulty soon after birth	___	___				
Walked alone when _____ months old			Eczema or hives	___	___	_____
Has child had:	No	Yes	Date			
Measles	___	___	_____	Unusual nervousness, nail biting		
Mumps	___	___	_____	or thumb sucking	___	___
Rubella	___	___	_____	Nightmares or trouble		
Chickenpox	___	___	_____	sleeping	___	___
Rheumatic Fever	___	___	_____	Breath holding or		
Asthma or wheezing	___	___	_____	temper tantrums	___	___
Pneumonia or Bronchitis	___	___	_____	Difficulty with toilet		
Frequent sore throats	___	___	_____	training or bed wetting	___	___
Frequent ear infections	___	___	_____	Any severe injury	___	___
Trouble with hearing	___	___	_____	Any operations	___	___
Trouble with speech	___	___	_____	Allergies to drugs or food. Please list.		

\_\_\_\_\_  
\_\_\_\_\_

Immunizations

Tuberculin Tests

Initial Series	Boosters	Date	Type	Reaction
DPT _____	_____	_____	_____	_____
DT _____	_____	_____	_____	_____
Oral Polio _____	_____	_____	_____	_____
MMR _____	_____	_____	_____	_____
HIB _____	_____	_____	_____	_____
HEP-B _____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Family Health History

Relation	Year of Birth	State of Health	Has any relation had	No	Yes	Relation
Father	_____	_____	Significant allergy	___	___	_____
Mother	_____	_____	Rheumatic fever	___	___	_____
Brothers	_____	_____	Heart Disease	___	___	_____
and	_____	_____	Diabetes	___	___	_____
Sisters	_____	_____	Tuberculosis	___	___	_____
	_____	_____	Convulsive disorder	___	___	_____
	_____	_____	Mental Illness	___	___	_____
	_____	_____	Cancer	___	___	_____

Additional Information: \_\_\_\_\_

\_\_\_\_\_

