Name: DOB: Year:

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QUICK GLANCE TREATMENTS

DATE	COMPLAINT	TREATMENT

ILLNESS TYPE First Aid Acute Chronic RESPONSE No Change Better Much Better

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Mother's Labor/Birth Notes:

_____
_____
_____
_____
_____
_____

Health Information:

Breastfed? Yes No If Breastfed, how long?_____ Self-weaned? Yes No

If bottle fed, formula type:

_____

Reactions to formula:

_____
_____
_____
_____

Food introduction notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Food Sensitivities/Allergies (date observed):

_____
_____
_____
_____
_____
_____

Name: DOB: Year:

Medicines given regularly:

Allergies to medication:

Vitamin/mineral supplements regularly given (1-4 years old):

5-12 years:

13-18 years:

Name: DOB: Year:

RECORD OF DENTAL VISITS

DATE	DENTIST NAME	REASON FOR VISIT	TREATMENT	RESPONSE