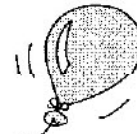


# du Ballon Rouge

Tourette Syndrome Association of Texas



## MEDICAL FORM To be completed by parent

CHILD'S NAME \_\_\_\_\_  
Last First Middle Initial

### HEALTH

Child's health, in general: Excellent \_\_\_ Average \_\_\_ Below average \_\_\_

Does your family currently have medical/hospital insurance? Yes \_\_\_ No \_\_\_ Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ Relationship to child \_\_\_\_\_

### TOURETTE SYNDROME SUMMARY

When was your child first diagnosed? \_\_\_\_\_

Describe motor and vocal tics \_\_\_\_\_  
\_\_\_\_\_

Describe obsessive-compulsive symptoms \_\_\_\_\_  
\_\_\_\_\_

Describe attention-deficit hyperactivity disorder symptoms \_\_\_\_\_  
\_\_\_\_\_

What interventions work best to help your child gain control? \_\_\_\_\_  
\_\_\_\_\_

### HEALTH HISTORY Please check all that apply and review with your child's physician at time of examination

\_\_\_ Asthma                      \_\_\_ Cerebral Palsy                      \_\_\_ Mental retardation                      \_\_\_ diabetes  
\_\_\_ Heart defect/disease                      \_\_\_ Frequent Ear Infections                      \_\_\_ Bleeding/clotting disorder

Other chronic or recurring illnesses, or handicapping conditions \_\_\_\_\_

### CHILDHOOD DISEASES Please record date (month and year) of infection

\_\_\_ German Measles                      \_\_\_ Mumps                      \_\_\_ Chicken Pox                      \_\_\_ Measles  
\_\_\_ Other - Please describe: \_\_\_\_\_

### IMMUNIZATION HISTORY

Please record date (month and year) of basic immunizations OR SEND COPY OF RECORD

\_\_\_ DPT Series                      \_\_\_ DPT Booster                      \_\_\_ Measles Vaccine (Live)  
\_\_\_ Polio OPV (Sabin)                      \_\_\_ Polio Booster                      \_\_\_ Mumps Vaccine (Live)  
\_\_\_ German Measles                      \_\_\_ Tetanus Booster                      \_\_\_ Tuberculin Test                      \_\_\_ Other

### MISCELLANEOUS

Please list any and all allergies (including drugs, plants, foods, etc.) \_\_\_\_\_

Operations or serious injuries (dates) \_\_\_\_\_

Does your child wear glasses, contacts, hearing aid, retainer, etc.? \_\_\_\_\_