Name _____

Birth date _____

BP: Pulse:

Child's Medical History

Physician's Name_____ Physician's Telephone_____

Physician's Address _____

1. Does your child have a specific medical condition that you want to discuss?.....Yes No
2. Is your child under a physician's care or has he been hospitalized recently?.....Yes No
3. Is your child taking medication?.....Yes No
4. Has your child ever had a heart problem, heart murmur or rheumatic fever?.....Yes No
5. Has your child ever had excessive bleeding after tooth extractions or cuts? .....Yes No
6. Does your child ever feel faint, dizzy, or have seizures?.....Yes No
7. Is your child allergic to:.....Yes No
   - ☐ penicillin ☐ other antibiotics ☐ metal ☐ latex
   - ☐ anesthetics ☐ other drugs Please specify: _____
8. Has your child ever received positive test results for:.....Yes No
   - ☐ tuberculosis ☐ hepatitis ☐ HIV or AIDS
9. Has your child ever had any of the following: .....Yes No
   - ☐ eyesight problems ☐ speech impairment ☐ loss of hearing ☐ heart problems
   - ☐ liver problems ☐ kidney problems ☐ stomach ulcers ☐ asthma
   - ☐ hay fever/bronchitis ☐ thyroid problems ☐ bleeding problems ☐ leukemia
   - ☐ cancer ☐ infection ☐ diabetes ☐ epilepsy
   - ☐ cerebral palsy ☐ pacemaker ☐ herpes ☐ venereal disease
   - ☐ mental retardation ☐ arthritis ☐ birth defect
10. Has your child been vaccinated for hepatitis B?.....Yes No

Comments

Update Information (Office Use Only)

Date	*Comment*	*Initials*	*Date*	*Comment*	*Initials*