Patient Name: **Date of Birth:** **Date:**

CHILD'S MEDICAL HISTORY

Child's Physician_____City/State_____Phone_____
Date of last physical exam_____Child's Vaccinations Updated YES NO
Current Medical Conditions_____
Any other specialist your child is currently seeing:_____

	Type:	Reason:	How often:
MEDICATIONS	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

List of ALLERGIES (*LATEX*, MEDICINES, FOODS., ETC):_____

	YES	NO	
Does your child have Congenital Heart Disease?	____	_____	Is SBE prophylaxis required?_____
Is child receiving any medication or drugs?	____	_____	List Medications_____
Has child ever been hospitalized?	____	_____	Is so, why?_____
Has child ever had surgery?	____	_____	List surgeries_____
Is there excessive bleeding when cut?	____	_____	Handicaps/Disabilities?_____

Does your child have, ever had or been diagnosed with any of the following (please check all that apply):

General
___Complications during pregnancy/birth
___Prematurity
___Cleft Lip/Palate
___Inherited Disorders
___Syndrome:_____
___Problems of growth or stature
___Currently Pregnant

Head, ears, eyes, nose, throat
___Chronic adenoid/tonsil infections
___Chronic ear infections
___Ear Problems
___Hearing Impairments
___Eye Problems
___Visual Impairments
___Sinusitis
___Speech impairments
___Apena/Snoring
___Mouth Breathing

Cardiovascular
___Heart Problem/Surgery
___Rheumatic Fever/Rheumatic heart disease
___High/Low Blood Pressure
___Heart Murmur

Respiratory
___Asthma
Medications_____
Last Attack_____
Hospitalizations_____
___Frequent colds/coughs
___Reactive Airway Disease
___Tuberculosis
___RSV
___Breathing Problems
___Cystic Fibrosis
___Smoking

Endocrine
___Diabetes
___Growth Delays
___Hormonal Problems
___Precocious Puberty
___Thyroid Problems

Integumentary
___Fever blisters
__Eczema
__Rash/Hives
__Dermatologic Conditions
__Cold/Sores

Gastrointestinal
__Eating Disorders
__Ulcer
__Excessive Gagging
__Gastroesophageal/acid reflux disease
__Hepatitis A, B or C
__Jaundice
__Liver Disease
__Intestinal Problems
__Prolonged diarrhea
__Unintentional weight loss
__Lactose Intolerance
__Dietary Restrictions

Genitourinary
__Bladder Infections
__Kidney Infections
__Systemic Birth Control
___Sexual Transmitted Disease

Musculoskeletal
___Arthritis
__Scoliosis
__Bone/Joint Problems
__TMJ problems-popping/clicking/locking
__Problems opening mouth or chewing

Neurologic
__Fainting
__Dizziness
__Autism
__Developmental Disorders
__Learning Problems/Delay
__Mental Disabilities
__Brain Injury
__Cerebral Palsy
__Convulsions/Seizures/Epilepsy
__Hydrocephaly/Shunts

Psychiatric
___Emotional Disturbance
___Hyperactivity/ADHD/ADD
___Psychiatric problems/treatment
___Alcohol and chemical dependency

Hematologic/lymphatic/immunologic
___Anemia
___Blood Disorders
___Blood Transfusions
___Excessive Bleeding
___Bruising easily
___Hemophilia
___Sickle Cell Disease/Trait
___Cancer-Type:_____
___Immune disorder
___Chemotherapy
___Radiation Therapy
___Bone Marrow Transplant

Infectious Disease
____Measles
____Mumps
___Rubella
___Varicella (Chickenpox)
___Mononucleosis
___Cytomegalovirus (CMV)
___Whooping Cough
___Scarlet Fever
___HIV/AIDS

Family History
___Genetic Disorders
___Problems with General Anesthesia
___Serious Medical Conditions/Illness

Social Concerns
___Passive Smoke Exposure
___Recreational Drug Use
___Religious or Philosophical objections to treatment

Other
_____
_____

I understand the information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Legal Guardian Signature:_____**Relationship to Child:**_____**Date:**_____