Medical History Update

DATE _____

Patient Name _____ Date of Birth _____

Your Phone and/or E-mail_____ Physician _____

Yes No
( ) ( ) Is patient in good health?

( ) ( ) Is patient under a physician's care? For What? _____

( ) ( ) Does patient have any history of major illness? What and When _____

_____

( ) ( ) Any hospitalizations in past 2 yrs? For what? _____

( ) ( ) Is patient taking any medications/drugs presently? What? _____

_____

( ) ( ) Does patient have any allergies or drug sensitivities? List:_____

_____

( ) ( ) Have tonsils and/or adenoids been removed? What age? _____

Does patient have tendency to colds( ), sore throat( ), ear infections( ), sinus congestion( ), breathing problems( )?

Check any of the following conditions for which the patient has been treated:

( ) AIDS	( ) Epilepsy/Seizures	( ) Liver/Kidney Disease
( ) Arthritis	( ) Emotional Problems	( ) Nutritional Problems
( ) Asthma	( ) Endocrine Problems	( ) Prolonged bleeding
( ) Blood Problems	( ) Fainting/Dizziness	( ) Rheumatic Fever
( ) Bone Disorders	( ) Heart Trouble	( ) Speech, Hearing Problems
( ) Cerebral Palsy	( ) Hepatitis	( ) Tonsillitis
( ) Diabetes	( ) HIV Positive	( ) Tuberculosis

Any other significant medical, psychological or disability problems? _____

_____

Any other medical or social information about your child about which we should know to help us improve their experience at our office? _____

_____

_____

Signature of Parent/Guardian

Employee: scan into "medical history" template