HEALTH HISTORY FOR CHILD

Name______________________________________ Home______________ Cell____________

Address ________________________________City_________________State_____Zip______

Date of Birth_________________Name of School______________________________________

Person responsible for bill_____________________________________Phone______________

In case of emergency who should we contact?______________________Phone_____________

Payment of services: Insurance Cash Budget Plan Medicaid

Circle yes or no for any of the following that you have had or have at the present:

High Blood Pressure yes/no
Asthma yes/no
Stroke yes/no
Angina yes/no
Diabetes yes/no

Heart Disease/Attack yes/no
HIV Positive or AIDS yes/no
Hepatitis Type______ yes/no
Arthritis yes/no
Use of tobacco Products yes/no

Heart Pace Maker yes/no
Tuberculosis (TB) yes/no
Sinus Problems yes/no
Anemia yes/no

*Mitral Valve Prolapse yes/no
*Rheumatic fever yes/no
*shunts/ports yes/no

*Artificial heart valves yes/no
*Artificial hip, knee, or other joints yes/no
*Heart Murmur yes/no

*Antibiotic pre-medication may be required prior to your appointment.

Are you allergic to (i.e. itching, swelling, or rash) or made sick by Penicillin, Aspirin, Codeine, Sulfa, Local Anesthetics, Latex, Metals? (Circle the ones that apply.)
Or any other medications? ____

List ALL medications that your are currently taking:___________________________________
____

Is there any other important health information we should know about you?_______________

Whom should we thank for referring you to our office? ___________________________________

To the best of my knowledge, all of the information on this form is true and correct. If there is an change in my health, I will inform the doctor prior to any treatment.

Signature____Date____________

Relationship to child____

I have reviewed my medical history and the above is accurate: Date______Initials______
Date______Initials______Date______Initials______Date______Initials______
Date______Initials______Date______Initials______Date______Initials______