Child's Name: _____
Has your address or phone changed? (please circle) Yes / No

MEDICAL HISTORY—Update

Check all that apply to your child:

□ Abnormal Bleeding/Bruising
□ HIV/AIDS
□ Anemia
□ Asthma/Breathing Problems
□ Autism Spectrum Disorder
□ Behavior/Emotional Problems
□ Bladder/Kidney Problems
□ Cerebral Palsy
□ Chemotheraphy
□ Cleft Lip and/or Palate
□ Convulsions/Seizures/Epilepsy
□ Cystic Fibrosis
□ Diabetes
□ Down Syndrome
□ Ear Infections
□ Fainting
□ Hearing Problems
□ Heart Murmur
□ Heart Problems
  □ Antibiotics required (Pre-med)
□ Hepatitis
□ Hyperactivity (ADD, ADHD)
□ Immune Problems
□ Learning Disorders
□ Liver Disorders
□ Malignancy (Cancer)
□ Muscular Dystrophy
□ Radiation Therapy
□ Sickle Cell Anemia
□ Sickle Cell Trait
□ Sleep Apnea
□ Stomach Problems
□ Syndromes (please specify)
□ Thyroid Problems
□ Tuberculosis
□ Vision Problems

□Check if none of the above apply to your child

--Does your child have any medical history or problem(s) not listed above? Please explain.
_____

--Does your child have any of the following allergies? (Check ALL that apply)
□Latex □Penicillin/Amoxicillin □Sulfa □ Nickel □Other:_____

□Check if your child does not have any drug allergies

--List all medication(s) that your child currently takes.
_____
--Has your child been hospitalized? □ Yes □No If yes, _____
--Is your child up to date on immunizations against childhood diseases? □ Yes □No

_____ _____
Parent or Guardian Signature Date

Office use:

ASA I II III