MEDICAL HISTORY UPDATE

Patient's Name: ______________________________

Address: ______________________ City: __________ Zip ________

Phone#: __________________ Email: ____________________

Gender: ________ Date of Birth: ____________

Medical Updates: ______________________________

Child's Physician: ____________________ Date of last exam: __________
Phone Number: ______________
Address: ____________________________

Is your child currently under the care of a physician? Y/N
(If yes, explain) ______________________
Is your child currently taking any medications? Y/N
(If yes, explain) ______________________
Has your child ever been hospitalized or had surgery? Y/N
(If yes, explain) ______________________
Does your child have any allergies to medicines, foods, or other materials? Y/N
(If yes, explain) ______________________

Does your child have a history of any of the following: (Please note any significant past medical history not listed under "other.")

Heart trouble or murmur	Y	N	Epilepsy	Y	N
Asthma	Y	N	Blood Disorders	Y	N
Hepatitis	Y	N	Liver Disease	Y	N
Rheumatic Fever	Y	N	Deafness	Y	N
Kidney Disease	Y	N	Premature Birth	Y	N
Anemia	Y	N	ADD/ADHD	Y	N
Seizures/Convulsions	Y	N	Autism	Y	N
Diabetes	Y	N	Other	Y	N
Cancer	Y	N	If other, please explain:		
Bleeding Problems	Y	N	______________________		
AIDS/HIV	Y	N			

Parent's Signature: ________________________ Date: __________

Doctor's Signature: ____________________