CHILD'S HISTORY

These questions are important so we have adequate information to take the best possible care of your child.

General Information		
Child's Name: Nickname:		
Name of Parent/Legal Guardian:		
Relationship to child:		
Madian Information		
Medical Information Child's physician: Phone #:		
Date of last physical exam:	·	Unknown
Does your child have a history of:		
Surgeries? Yes No List type:		
Immunizations up to date? Yes		
Please circle if your child has a history of		Tuberculosis (TB)
Heart disease or murmur	Epilepsy, seizures, fainting	Gastrointestinal issues
Asthma	Developmental delay	Thyroid disease
Blood disorder	Behavioral/emotional problems	Hearing or vision problems
Blood transfusion	Arthritis	Speech delay
Diabetes	Motor or muscle disorder	Tobacco use
Liver disease	Cancer or tumors	Chemical dependency
Kidney disease	HIV/AIDS	Premature birth (Weeks?)
Females only: Is there any possibility of pregnancy? Yes No Not applicable		
Taking birth control? Yes No Not applicable Does your child have any other medical issues or special needs? Yes No Please list:		
Does your child have any other medical issues of special needs:		
Signature of Parent/Guardian: Date:		
Office Use Only		
Medical History Update		
Date: Comments:		Comments:
Parent signature:		gnature:
Date: Comments:		Comments:
Parent signature:		gnature:
Date: Comments:		Comments:
Parent signature:		gnature:
Date: Comments:		Comments:
Parent signature:		gnature:
Date: Comments:		Comments:
Parent signature:		gnature:
Date: Comments: Parent signature:		Comments:
	Tarchit sig	anature.
		gnature:
	Date:	Comments:
Parent signature:	Date: Parent sig	gnature:
Date: Comments:	Date: Parent sig	Comments: gnature: Comments:
	Date: Parent signal par	gnature: