

Medical History

Condition of child's health \_\_\_\_\_

Date and reason for last medical exam \_\_\_\_\_

Names of any medications taken recently by your child \_\_\_\_\_

Has your child ever been allergic to any medicine, food or substance \_\_\_\_\_

If so, please list \_\_\_\_\_

Has your child ever bled excessively from a cut or injury, or bruised easily \_\_\_\_\_

Has your child any history of difficulty with any of the following:

\_\_\_\_ Anemia

\_\_\_\_ Diabetes

\_\_\_\_ Liver

\_\_\_\_ Asthma

\_\_\_\_ Digestion

\_\_\_\_ Malignancies

\_\_\_\_ Autism

\_\_\_\_ Epilepsy

\_\_\_\_ Measles

\_\_\_\_ Bladder

\_\_\_\_ Fainting

\_\_\_\_ Mononucleosis

\_\_\_\_ Cerebral Palsy

\_\_\_\_ Glands

\_\_\_\_ Mumps

\_\_\_\_ Chicken Pox

\_\_\_\_ Hearing

\_\_\_\_ Rheumatic Fever

\_\_\_\_ Chronic Sinus

\_\_\_\_ Heart

\_\_\_\_ Thyroid

\_\_\_\_ Colds

\_\_\_\_ Kidney

\_\_\_\_ Tuberculosis

\_\_\_\_ Convulsions

Other: \_\_\_\_\_

Has your child ever been hospitalized \_\_\_\_\_ Give details \_\_\_\_\_

Has your child any emotional problems \_\_\_\_\_

How does your child accept this/her physician \_\_\_\_\_

Important! Please inform our office prior to any visit of

Any change in your child's physical or emotional health

Any medication taken by your child within 48 hour before appointment