Updated Medical History

Child's
Name_____Age_____Birthdate_____

Address_____

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 his/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

Parent's signature_____Date_____