MEDICAL HISTORY

Name_____ DOB_____

Name of Pediatrician_____ Office Phone_____

Does your child have any of the following medical concerns:

General Conditions

_____Arthritis
_____Asthma
Controlled?_____
Last Attack?_____
_____Diabetes
_____Gastrointestinal Disorder
_____Heart Disease
_____Heart Murmer
_____Kidney Disease
_____Rheumatic Fever

Behavior/Learning

_____ADD/ADHD
_____Anxiousness/Nervousness
_____Autism
_____Asperger Syndrome
_____Behavioral Issues
_____Learning Disabilities
_____Psychiatric Disorder

Developmental

_____Brain Injury
_____Cerebral Palsy
_____Cleft/Lip Palate
_____Developmental Delay
_____Feeding/Eating problems
_____Growth Problems
_____Hearing Loss
_____Neuromuscular Defect
_____Orthopedic Problems
_____Seizures: Type_____
_____Speech Delay
_____Spina Bifida

Hematological (Blood Related)

_____Anemia
_____Hemophilia
_____Sickle Cell Trait
_____Sickle Cell Disease
_____Blood Transfusion

Infectious

_____Hepatitis
_____HIV Infection
_____AIDS
_____Tuberculosis

Other

_____Adenoids
_____Cancer
_____Leukemia
_____Fainting
_____Headaches
_____Skin Disorder
_____Sleep Apnea
_____Snoring
_____Latex Allergy
_____Tonsils/Removed?___
_____Tubes in ear
_____Other
_____Pregnancy

If checked, please describe further_____

_____

Were there any difficulties during the pregnancy/delivery of your child?_____

If yes, please describe_____

_____

Has your child been hospitalized since birth?_____

If yes, please describe_____

_____

Are your child's immunizations up to date?

_____Yes _____No

Allergies

Has your child had any allergic reactions to the following?

Medications_____ Explain_____

Latex_____ Explain_____

Foods_____ Explain_____

Other_____ Explain_____

Is your child currently taking any medications?_____

Drug	How much/How often	Reason

Have you ever been told your child requires antibiotic prophylaxis for dental treatment due to a medical condition? _____Yes _____No

If yes, explain_____

Physician following medical condition:

Name_____ Office Phone_____

(Over Please)