

WELCOME TO OUR OFFICE

GENERAL MEDICAL INFORMATION

Patient Name: _____

Reason for Today's Appointment: _____

How Long has this been a problem: _____

What treatment has been prescribed for the above: _____

Please list: Height _____ Weight _____

Are immunizations up to date? Yes No

Does child bruise easily? Yes No

Has child ever had a cut in which bleeding was difficult to control Yes No

PERSONAL MEDICAL HISTORY

Has your child ever had any of the following? (Check ALL that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Any Heart Problems | <input type="checkbox"/> Neuro-Muscular Problems | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Snoring | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ | |

SURGICAL HISTORY

Please list any previous surgeries and the year surgery was performed. _____

Do you have any objection to the use of blood products in the unlikely event they should become necessary? Yes No

Has your child or any family member had a reaction to any local or general anesthetic? Yes No

If Yes, what type of reaction? _____

FAMILY HISTORY

Does anyone in your immediate family have a history of any of the following? (Check ALL that apply)

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney or Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Loss |

ALLERGIES

Does your child have any allergies to medications? Yes No

If Yes, please list:

Medication

Type of Reaction

_____	_____
_____	_____
_____	_____

Allergic to Latex? Yes No

Allergic to x-ray dye? Yes No

MEDICATIONS

Does your child take any medications on a regular basis? Yes No

List all Medications:

Medication

Dose

Medication

Dose

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PARENT'S SIGNATURE _____ DATE _____ STAFF _____