Medical History Update

PATIENTS NAME _____ **DOB** _____

- ☐ YES ☐ NO ADHD/ADD
- ☐ YES ☐ NO AIDS/HIV
- ☐ YES ☐ NO ALCOHOL USE
- ☐ YES ☐ NO ASTHMA
- ☐ YES ☐ NO AUTISM
- ☐ YES ☐ NO ANEMIA
- ☐ YES ☐ NO BIPOLAR
- ☐ YES ☐ NO BIRTH DEFECT
- ☐ YES ☐ NO BLOOD TRANSFUSION
- ☐ YES ☐ NO BONE/JOINT PROBLEMS
- ☐ YES ☐ NO BRAIN INJURY
- ☐ YES ☐ NO CEREBRAL PALSY
- ☐ YES ☐ NO CANCER/TUMOR
- ☐ YES ☐ NO CHEMICAL DEPENDENCY
- ☐ YES ☐ NO CHEMOTHERAPY/RADIATION
- ☐ YES ☐ NO CHICKEN POX
- ☐ YES ☐ NO CHILD ABUSE
- ☐ YES ☐ NO CHRONIC COUGH
- ☐ YES ☐ NO CLEFT PALATE/LIP
- ☐ YES ☐ NO COLD SORES/CANKER SORES
- ☐ YES ☐ NO COLIC
- ☐ YES ☐ NO DEPRESSION
- ☐ YES ☐ NO DEVELOPMENTALLY DEALAYED
  AGE LEVEL: _____
- ☐ YES ☐ NO DIABETES
- ☐ YES ☐ NO EARACHES/EAR INFECTIONS
- ☐ YES ☐ NO EPILEPSY/SEIZURE DISORDER
- ☐ YES ☐ NO EYE CONDITIONS
- ☐ YES ☐ NO FEMALES: ARE YOU PREGNANT?
- ☐ YES ☐ NO FEMALES: ARE YOU TAKING BIRTH CONTROL MEDICATION?
- ☐ YES ☐ NO HAY FEVER
- ☐ YES ☐ NO HEARING INMPAIRMENT/ DEAF
- ☐ YES ☐ NO HEART DISEASE
- ☐ YES ☐ NO HEART MURMUR
- ☐ YES ☐ NO HEMOPHILIA
- ☐ YES ☐ NO HEPATITIS/LIVER DISEASE
- ☐ YES ☐ NO HIGH BLOOD PRESURE
- ☐ YES ☐ NO INJURY TO FRONT TEETH
- ☐ YES ☐ NO KIDNEY DISEASE
- ☐ YES ☐ NO MENTALLY HANDICAPPED
- ☐ YES ☐ NO METALLIC IMPLANT, SHUNTS, PINS/RODS
- ☐ YES ☐ NO NERVOUS/ANXIETY DISORDER
- ☐ YES ☐ NO PREMATURE BIRTH
- ☐ YES ☐ NO PROLONGED BLEEDING WHEN CUT
- ☐ YES ☐ NO PSYCHIATRIC CARE
- ☐ YES ☐ NO RHEUMATIC FEVER
- ☐ YES ☐ NO SCARLET FEVER
- ☐ YES ☐ NO SHORTNESS OF BREATH
- ☐ YES ☐ NO SICKLE CELL DISEASE
- ☐ YES ☐ NO SINUSITIS
- ☐ YES ☐ NO SMOKE
- ☐ YES ☐ NO SORE THROATS
- ☐ YES ☐ NO SPECIAL DIET
- ☐ YES ☐ NO SPEECH IMPAIRMENT/MUTE
- ☐ YES ☐ NO THYRIOD DISORDER
- ☐ YES ☐ NO TONSILLITIS
- ☐ YES ☐ NO TRANSPLANTS SPECIFY ORGAN
  _____
- ☐ YES ☐ NO TUBERCULOSIS
- ☐ YES ☐ NO ANY MAJOR SURGERY
- ☐ YES ☐ NO OTHER: PLEASE SPECIFY:
  _____
- ☐ YES ☐ NO Immunizations up to date
- ☐ OTHER: _____
  _____

DOES YOUR CHILD/ADOLESCENT HAVE ANY HISTORY OF ALLERGIES OR UNFAVORABLE REACTIONS TO ANY OF THE FOLLOWING MEDICATIONS

- ☐ AMOXICILLIN
- ☐ PENICILLIN
- ☐ BARBITURATES
- ☐ LATEX
- ☐ ASPRIN
- ☐ CODEINE
- ☐ LOCAL ANESTHETICS
- ☐ GENERAL ANESTHETICS
- ☐ AUGMENTIN
- ☐ SULFA DRUGS
- ☐ OTHER: _____

IS YOUR CHILD/ADOLESCENT CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO
IF YES, WHAT KIND:

Medical History Review / For Office use Only			
Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____	Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____	Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____	Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____ Signed: _____ Date: _____

Our office updates all patient's medical history every 6 months in order to protect our patient's and staff's safety.
Please mark all that apply. Mark none in none apply.