

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for your child. This office does not use this information to discriminate.

	<u>YES</u>	<u>NO</u>
Have you or your child had any of the following diseases or problems?		
Active tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than 3 week duration	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>

	<u>YES</u>	<u>NO</u>
1. Is the child in good health?	<input type="checkbox"/>	<input type="checkbox"/>
2. Please list the name(s) of the child's physician:		
_____		
_____		
3. Is the child currently being treated for any illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what is/are the condition being treated: _____		
_____		
_____		
4. Is the child taking any medications at this time?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____		
_____		
_____		
5. Is the child allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain: _____		
_____		
6. Has the child had any serious illness, operation, or been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what was the illness or problem?		
_____		
_____		

7. Please (X) a response to indicate if your child has or has not had any of the following diseases or problems:

	<u>YES</u>	<u>NO</u>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, chemotherapy/radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease:	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify below:		
<input type="checkbox"/> Artificial heart valves	<input type="checkbox"/> Heart surgery	
<input type="checkbox"/> Congenital heart defect	<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Damaged heart valves	<input type="checkbox"/> Low blood pressure	
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Rheumatic fever/Rheumatic heart disease		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any other disease, condition, or problem not listed above that you think I should know about?	<input type="checkbox"/>	<input type="checkbox"/>

*I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my child's treatment. To the best of my knowledge, the information above is complete and accurate.*

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Initials

## CHILD MEDICAL HISTORY (0-12 YEARS)