Medical Health History

Patient Name: DOB: / / Date: / /

Responsible Party's Name: Patient's Sex: ☐ M ☐ F

1. Are you being treated by a physician at this time? ☐ Yes ☐ No

   Physician's Name: Physician's Phone Number:

   When was your last visit to this physician? Date: / /

2. Have you ever been a patient in a hospital? ☐ Yes ☐ No
3. Have you ever had any major illness or surgery? ☐ Yes ☐ No

   If so, please specify:

4. Do you have any allergies to any medication or substance (eg: medication, latex, foods, etc.)? ☐ Yes ☐ No

   If so, please specify:

5. Are you taking any medications or substances at this time? ☐ Yes ☐ No

   If so, please specify:

6. Do you have any problems with local anesthetics, antibiotics or any other types of medication? ☐ Yes ☐ No

   If so, please specify:

7. Are you pregnant or suspect that you might be pregnant? ☐ Yes ☐ No
8. Do you take birth control medication? ☐ Yes ☐ No
9. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Yes ☐ No

10. Have you ever had treatment or medical consultation for any of the following?

☐ Blood/Circulatory System	☐ Eyes	☐ Liver	☐ Nose
☐ Bones	☐ Gastrointestinal/Stomach	☐ Lungs	☐ Skin
☐ Ears	☐ Heart	☐ Muscles	☐ Throat
☐ Endocrine Glands	☐ Kidney/Bladder	☐ Nervous System	☐ Tonsils/Adenoids

☐ I have NOT had treatment for any of the above?

11. Have you ever been diagnosed with any of the following conditions?

☐ ADD/ADHD	☐ Brain Injury	☐ Heart Disease	☐ Pneumonia
☐ Allergy	☐ Cancer	☐ Leukemia	☐ Rheumatic Fever
☐ Anemia/Trait	☐ Cerebral Palsy	☐ Hemophilia	☐ Sickle Cell
☐ Arthritis	☐ Convulsions/Seizures	☐ Hepatitis	☐ Snoring
☐ Artificial Heart Valve	☐ Diabetes	☐ High Blood Pressure	☐ Speech Problems
☐ Artificial Joints/Prosthesis	☐ Emotional Disturbances	☐ HIV/AIDS	☐ Spina Bifida
☐ Asthma	☐ Epilepsy	☐ Latex Allergy	☐ Tuberculosis
☐ Autism	☐ Eye Problems	☐ Learning Disability	
☐ Behavioral Problems	☐ Fainting	☐ Heart Murmur or Condition	
☐ Bleeding Problems	☐ Hearing Loss	☐ Obstructive Sleep Apnea	

12. Is there anything else we should know about your health that we have not covered in this form? ☐ Yes ☐ No

    If so, please specify:

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my health.

Patient / Guardian Signature: Date: / /

Doctor's Signature: Date: / /

Health History Update: Are there any changes to your child's medical history?

☐ Yes ☐ No Patient / Guardian Signature: Date: / /

Health History Update: Are there any changes to your child's medical history?

☐ Yes ☐ No Patient / Guardian Signature: Date: / /