**Child Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# **General**

Does your child have a primary care physician?  Yes  No If yes, who?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Name Practice Phone Number

Has your child ever had surgery?  Yes  No If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any of the following conditions? Please circle all that apply.

Anemia

Arthritis

Asthma

Behavioral/learning problems

Blood disorders

Breathing problems

Cancer

Chemotherapy/radiation

Cold sores

Diabetes

Dizziness

Emphysema

Epilepsy/seizures

Excessive bleeding

Fainting spell/dizziness

Glaucoma

Heart attack

Hemophilia

Hepatitis A

Hepatitis B/C

High blood pressure

Hives/rash

Irregular heartbeat

Kidney problems

Leukemia

Liver problems

Low blood pressure

Lung disease

Mitral valve prolapse

Osteoporosis

Renal dialysis

Shingles

Sickle Cell Anemia

Sinus problems

Stomach problems

Stroke

Thyroid disease

Tonsillitis

Tuberculosis

Tumors/growths

# **Allergies**

Is your child allergic or sensitive to any of the following?

 Latex  Penicillin  Aspirin  Codeine  Plastic  Acrylic  Local Anesthetics  Metals

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Medications**

Is your child taking any medications, vitamins, supplements, pills, or drugs?  Yes  No If yes,

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dosage | Date started | For what reason? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Patient/guardian signature indicates the above information is complete and accurate.