Medical History Update Form

Child's Name_____ Age_____

Parent's Name_____

Address_____

Home Phone_____ Cell Phone_____

Mother Employer _____ Work Phone_____

Father Employer _____ Work Phone_____

Alternate Contact Name_____ Phone_____

Has your insurance information changed since the last visit? YES NO

If yes, please give new information to front office staff.

Child's Physician_____ Phone_____ date last seen_____

Address_____ City_____ State____ Zip_____

Is the child currently under the care of a physician? YES / NO
Please explain_____

Please list ALL medications that your child is currently taking:_____

Please list ALL drug allergies/ or other reactions:_____

Is your child pregnant? Due Date?_____ Current on Immunizations?_____

Has the child had the following:

Y/N abnormal bleeding Y/N rheumatic fever Y/N asthma, wheezing
Y/N anemia Y/N heart disease Y/N cerebral palsy
Y/N blood transfusions Y/N heart murmur Y/N cystic fibrosis
Y/N hemophilia Y/N congenital heart defect Y/N epilepsy, seizures, fainting
Y/N diabetes Y/N sickle cell, carrier, or trait
Y/N thyroid/endocrine disorder
Y/N headaches, head injury or loss of consciousness
Y/N tuberculosis (TB) Y/N hepatitis or jaundice Y/N allergies
Y/N liver/stomach/intestinal problems Y/N lung problems
Y/N eating disorders Y/N sensory disorder Y/N cancer/tumors
Y/N kidney problems, urinary tract infections or bed wetting
Y/N radiation or chemotherapy Y/N AIDS/ HIV + Y/N hospital stays/operations

Any history of mental or physical developmental delays?_____
Any learning, behavioral, or communication problems?_____
Any history of congenital birth defects?_____

Signed_____ Date_____