PATIENT HEALTH FORM:

Patient's Name: _____ Today's Date ___/___/___

Birthdate ___/___/___ Age:_____ M ❑ F ❑

Phone: Home#_____ Cell#_____

Address change? Y ❑ N ❑ If Yes - Address:_____

Physician_____ Phone# _____ Last Seen _____

Specialist_____ Phone# _____ Last Seen _____

Yes No Please check box if your child has or has had any of these conditions:

❑ ❑ Immunizations up to date: _____

❑ ❑ Heart Problems: _____

What Type _____ is Pre-Med needed?_____

❑ ❑ Blood Pressure Problems: High____Low____Meds_____

❑ ❑ Bleeding Disorder: _____

❑ ❑ Anemia: _____ Meds _____

❑ ❑ Arthritis: _____ Meds _____

❑ ❑ Frequent / Severe Headaches: _____

❑ ❑ Thyroid Problems: High___ Low ___ Meds_____

❑ ❑ Frequent Ear Infections: _____Tubes?_____Date ___/___/___

❑ ❑ Hearing Loss _____ Left _____ Right _____ Hearing Aids _____

❑ ❑ Persistent Cough or Swollen Glands: _____

❑ ❑ Tonsil or Adenoid Problems: Y ❑ N ❑ Removed? Y ❑ N ❑ Date ___/___/___

❑ ❑ Asthma: _____ Inhalers _____ Nebulizer_____

❑ ❑ Reflux: _____ Meds _____

❑ ❑ Diabetes: Type 1 _____ Type 11 _____ On Insulin _____ Pump _____

❑ ❑ TB or Respiratory Problems: _____

❑ ❑ Hepatitis _____

❑ ❑ ADD _____ ADHD _____ Meds _____

❑ ❑ Sensory Integration: _____

❑ ❑ Autism: _____

❑ ❑ Birth Defects: _____

❑ ❑ Epilepsy / Seizures: _____

❑ ❑ Cerebral Palsy: _____

❑ ❑ Down Syndrome: _____

❑ ❑ HIV _____

❑ ❑ MRSA _____ Date ___/___/___ Infection Site _____

Allergies: _____EPI Pen? Y ❑ N ❑

Meds _____

Parents Signature: _____ Printed Name:_____

Dentists Signature: _____Witness Initial:_____

/ Office Notes: /

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