Medical History

Patient Name _____
Does this child have any medical conditions? _____
Is this child under the care of a physician? (Yes) (No) Name:_____
Date of last physical? _____
Are this child's immunizations up to date?_____
Medications?_____
Allergies?_____
Hospitalizations and surgeries?_____
Does this child require premedication?_____

Review of Systems
Has this child ever had medical problems related to the following?

Circulatory-blood	yes	no	Muscles	yes	no
Endocrine	yes	no	Nervous system	yes	no
Eye, ears, nose, throat	yes	no	Respiratory-lungs	yes	no
Gastrointestinal-stomach	yes	no	Skeleton-bones	yes	no
Heart	yes	no	Skin	yes	no
Liver	yes	no	Urinary tract, kidneys, bladder	yes	no

Medical Conditions
Has your child been diagnosed with any of the following conditions?

HIV/Aids	yes	no	Heart disease/murmur	yes	no
ADD/ADHD	yes	no	Hemophilia	yes	no
Anemia	yes	no	Hepatitis	yes	no
Asthma	yes	no	Jaundice	yes	no
Autism Spectrum	yes	no	Leukemia	yes	no
Bleeding disorders	yes	no	Measles	yes	no
Brain Injury	yes	no	Mental delay	yes	no
Bronchitis	yes	no	Mumps	yes	no
Cancer	yes	no	Pneumonia	yes	no
Cerebral Palsy	yes	no	Pregnancy	yes	no
Chicken Pox	yes	no	Psychiatric problems	yes	no
Cleft lip/palate	yes	no	Rheumatic fever	yes	no
Communicable diseases	yes	no	Scarlet fever	yes	no
Developmental delay	yes	no	Scoliosis	yes	no
Diabetes	yes	no	Sickle cell anemia	yes	no
Substance abuse	yes	no	Sinus problems	yes	no
Epilepsy/seizures	yes	no	Sore throat	yes	no
Endocrine/growth	yes	no	Enlarged tonsils	yes	no
Eye problems	yes	no	Spina bifida	yes	no
Fainting/dizziness	yes	no	Tuberculosis (TB)	yes	no
Hearing loss	yes	no	Other_____		

_____

Guardian's name_____
Guardian's signature_____ Date_____