Patient Name: Birth Date: Date Created:

Pediatrican

Does your child have a current Pediatrican or Primary Doctor? If so please type address and phone number below. ◯ Yes ◯ No If yes

Does your child have any physical or learning disablities, or attending any therapy? If so please list ◯ Yes ◯ No If yes

Was your child born premature? ◯ Yes ◯ No If yes

Is your child currently being seen by a physician on a regular bases? (ex: monthly, weekly etc.) ◯ Yes ◯ No If yes

Has your child ever had a head or neck injury? (Ex: Hit to the face, head or teeth) ◯ Yes ◯ No If yes

Does your child snore or have obstructive sleep apnea? ◯ Yes ◯ No If yes

Has your child ever been hospitalized or had any operations? If so please list the type and when the surgery ◯ Yes ◯ No If yes

Does your child take any medication(s) regularly? If so please list all medication(s) and dosage your child is taking ◯ Yes ◯ No If yes

Is your child allergic to any of the following? List any if not shown below. (especially fruits and foods)

Latex	◯ Yes ◯ No	Local Anesthetics	◯ Yes ◯ No	Sulfa Drugs	◯ Yes ◯ No	Penicillin/amoxicillin/augmentin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No	Metal	◯ Yes ◯ No	Dairy	◯ Yes ◯ No	Nuts (any)	◯ Yes ◯ No
Eggs	◯ Yes ◯ No	Soy	◯ Yes ◯ No	Milk protein	◯ Yes ◯ No	Lactose Intolerant	◯ Yes ◯ No

Does your child take any oral contraceptives? ◯ Yes ◯ No If yes

Has or is your child pregnant? ◯ Yes ◯ No

Does your child have, or had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Autism	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	Kawasaki Disease	◯ Yes ◯ No	Asperger's Syndrome	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Croup	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No
Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Hand,foot,mouth disease	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Whooping Cough	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Heart Murmur - No pre medication need	◯ Yes ◯ No	Pre medication required for dental treat	◯ Yes ◯ No	Down Sydrome	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Chicken Pox	◯ Yes ◯ No	MRSA	◯ Yes ◯ No	ADHD	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Depression	◯ Yes ◯ No	Sexually transmittal disease	◯ Yes ◯ No	Splenectomy	◯ Yes ◯ No
Cerebral Palsy	◯ Yes ◯ No	Broken bone requiring metal plate/pins/s	◯ Yes ◯ No				

List any medical conditions not mentioned above and explain. ◯ Yes ◯ No

Habits

Does your child have any of the following habits?

Thumb sucking	◯ Yes ◯ No
Finger/Blanket sucking	◯ Yes ◯ No
Pacifier	◯ Yes ◯ No
Grinding	◯ Yes ◯ No
Nail Biting	◯ Yes ◯ No

I have read all the questions listed and answered them to the best of my knowledge that everything is correct.

Signature of Patient, Parent or Guardian:

X Date:_____