Child Medical History

Patient First Name *

Patient Last Name *

Has your child ever had any of the following medical conditions?

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies - Seasonal
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Conditions
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Heart Valve
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Mitral Valve Prolaps
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Does your child have any other health problems? *

- ( ) No ( ) Yes

Is your child allergic to any of the following?

- [ ] Penicillin
- [ ] Tetracycline
- [ ] Sulfa drugs
- [ ] Aspirin
- [ ] Codeine
- [ ] Latex
- [ ] Metals
- [ ] Dental Anesthetics
- [ ] Other allergies

Other allergies not listed above

Is your child taking any medications at this time? *

No Yes

Has your child been admitted to the hospital in the last 2 years? *

No Yes

Is your under care of physician? *

No Yes

To the best of my knowledge, all of the precedings answers and information provided are true and correct. If there is ever have any changes in my child's health, I will inform the doctors at the next appointment without fail.

Draw your signature into the box below. *

Clear

Relationship to the patient *

Name if not the patient *

Continue