PEDIATRIC MEDICAL HISTORY FORM

Ages 0-13

Child's Full Name: _____ Date of Birth: _____

Pediatrician's Name: _____Date of Last Visit with Pediatrician: _____
Pediatrician's Phone Number: _____

Has your child ever had any of the following conditions? (Please check all that apply)

___Asthma or breathing problems
___Frequent colds or coughs
___Heart condition or murmur
___Seizures or epilepsy
___Diabetes or A1C
___Bleeding or bruising easily
___Anemia (low iron)
___Hearing or vision problems
___Hepatitis or liver problems
___HIV Positive
___Kidney or urinary problems
___Allergies (medications, foods, etc.)
___Developmental delays
___Behavioral or learning concerns
___History of serious illness or surgery
___Does your child snore
___Ear Tubes

If you checked "Yes" to any, please provide more details:

MEDICATIONS AND ALLERGIES

List any Vitamins or medications your child is taking:

List any allergies (medications, food, latex, etc.):

ADDITIONAL INFORMATION

Has your child ever been hospitalized or had surgery? (tonsil removal, tongue tie release) YES / NO
If yes, please explain:

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is correct. I will inform the office of any changes in my child's health.

Parent/Guardian Name (printed): _____
Signature: _____ Date: _____

Dentist Signature: _____ Date: _____