MEDICAL HISTORY - CHILD

Patient Name____________________ Nickname__________ Age________
Name of Physician and their Specialty____________________
Most Recent Physical Examination________________ Purpose________________

	Yes	No
1. Has your child ever been hospitalized, had surgery, or significant injury?	☐	☐
Reason/Description:		
2. Is your child being treated by a physician at this time?	☐	☐
Reason/Description:		
3. Has your child ever had a reaction/problem with anesthetic?	☐	☐
Describe:		
4. Has your child had a reaction or allergy to an antibiotic?	☐	☐
If yes, which one?		
5. Is your child allergic to latex or anything else? (metals, dyes, acrylic)	☐	☐
List:		
6. Is your child up to date with their immunizations against childhood diseases?	☐	☐
7. Is your child immunized against Human Papiloma Virus (HPV)?	☐	☐

Does your child have a history of the following conditions (if yes circle & describe below)

	Yes	No
8. Sinusitis, chronic adenoid/tonsil infections	☐	☐
9. Sleep apnea/snoring, mouth breathing, or excessive gagging	☐	☐
10. Congenital heart defect/disease, heart murmur, rheumatic heart disease	☐	☐
11. Asthma, reactive airway disease, wheezing, or breathing problems	☐	☐
12. Frequent colds or coughs, or pneumonia	☐	☐
13. Jaundice, hepatitis, or liver problems	☐	☐
14. Bladder or kidney problems	☐	☐
15. Rash, hives, or skin problems	☐	☐
16. Autism/autism spectrum disorder	☐	☐
17. Attention deficit/hyperactivity disorder (ADHD)	☐	☐
18. Behavioural, emotional, communication, or psychiatric problems/treatment	☐	☐
19. Diabetes, hyperglycemia, or hypoglycemia	☐	☐

Provide any additional details here:____________________

20. Is your child taking any medications (prescription or over the counter), vitamins, dietary supplements?

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Signature of Parent | Date | Dr. Aaron Snidal