MEDICAL HISTORY

DOES YOUR CHILD HAVE OR HAD ANY OF THE FOLLOWING ?

Yes	No		Yes	No	
		ASTHMA OR ANY RESPIRATORY DISEASES			ANY HEART PROBLEMS INCLUDING HEART MURMUF
		HEPATITIS OR YELLOW JAUNDICE			HIGH OR LOW BLOOD PRESSURE
		RHEUMATIC FEVER			NERVOUS PROBLEMS
		ARTIFICIAL JOINTS OR HEART VALVE PROSTHESIS			PSYCHIATRIC CARE
		BLOOD TRANSFUSION			RADIATION THERAPY OTHER THEN DIAGNOSTIC X-ra
		RHEUMATISM OR ARTHRITIS			ANEMIA OR ANY BLOOD DISORDERS
		TUMORS OR GROWTHS			DIABETES HOW LONG ? _____
		THYROID CONDITION			DRUG OR ALCOHOL DEPENDENCE
		LIVER, KIDNEY, STOMACH OR INTESTINAL DISEASES			AIDS OR HIV POSITIVE
		VENEREAL DISEASE			ALLERGIES TO ANESTHETIC
		EPILEPSY			ALLERGIES TO LATEX
		MITRAL VALVE PROLAPSE			IS SHE PREGNANT ?

List all medications your child is now taking. _____

_____

Is your child allergic to any medications ? _____ If so, please list _____

_____

Any other medical conditions we should be aware of ? _____

_____

X _____

Signature Date

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DATE	SERVICES	CHARGES