HEALTH HISTORY

Child's physician _____ Phone _____
Address _____
Date of last examination _____ Results _____

Is child under care of physician now _____
Is child receiving any medications or drugs _____
Is there any excessive bleeding when cut _____
Has child ever been hospitalized _____
Has child ever had surgery _____
Is there any allergy to penicillin or other drugs _____
Are there other allergies: food, pollen, animals, dust, etc. _____
_____
Does child have good physical coordination _____
Are there any emotional problems _____

Has the child any history of or difficulty with any of the following:

__Anemia	__Chronic sinus	__Hearing	__Mastoid	__Thyroid
__Asthma	__Convulsions	__Heart	__Measles	__Tuberculosis
__Bladder	__Diabetes	__Kidney	__Mononucleosis	__Venereal disease
__Cerebral Palsy	__Epilepsy	__Liver	__Mumps	__Other _____
__Chicken pox	__Fainting	__Malignancies	__Rheumatic fever	_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed.

_____
_____
_____
_____

I authorize release of this child's records from current medical physician(s) and previous dentist.____yes
Your name _____Date _____
Relationship to child _____

TO BE FILLED OUT BY CLINICAL STAFF

Summary _____
_____
_____
_____
_____
_____
_____

completed by _____*date*_____