



Child Health History

PATIENT INFORMATION

(CONFIDENTIAL)

Today's Date _____

Name: _____ Date of Birth: _____ Age: _____

Nickname: _____ Sex: _____ Height: _____ Weight _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #: _____

RESPONSIBLE PARTY

Name of Person Responsible for the Account: _____

Relationship to Patient: _____ Driver's License #: _____ Birth Date: _____

Home Phone: _____ Cell Phone/Pager: _____ Fax: _____

Email: _____ Social Security# _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone #: _____

MEDICAL HISTORY

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

Y N Allergies to any drugs	Y N Diabetes	Y N Phen-Fen Use present/past
Y N Any Hospital Stays	Y N Seizures / Epilepsy	Y N Tuberculosis
Y N Any Operations	Y N Handicaps / Disabilities	Y N Heart Murmurs
Y N Latex Allergy	Y N Cancer	Y N Kidney Problems
Y N Bleeding Problems	Y N Rheumatic / Scarlet Fever	Y N Developmentally Delayed
Y N Hearing Impairments	Y N Heart Defects	Y N Cerebral Palsy
Y N Asthma / Lung Problems	Y N Hepatitis / Liver problems	

Weight _____ Height _____

Please discuss any medical problems that the child has/had: _____

Child's Physician: _____ Phone Number: _____

Is your child currently under the care of a physician: Yes ___ No ___ Date of Last Visit: _____

Please describe child's current physical health: Excellent _____ Good _____ Poor _____

Please list all medications the child is currently taking: _____

Please list all allergies the child has including medications: _____

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Misra of any changes in my medical status at the earliest possible time.

Signature of Patient _____ Date _____

Reviewed by: _____ Date _____