ANY PERSONAL INFORMATION CHANGES YES/NO

CHILD'S NAME: _____ Home Phone _____

Cell _____work_____ other number_____

Home Address _____ City _____

State _____ Zip Code _____

EMERGENCY INFORMATION: In case of an emergency whether neither parent nor legal guardian can be reached, please identify the following information for the next closest relative **NOT** living with the patient.Name _____Relation_____

Phone_____address,City,Zip_____

ANY MEDICAL HISTORY CHANGES YES/NO

Has your child ever had any of the following conditions?

YES	NO		YES	NO	
O	O	Anemia	O	O	Hearing Impairment (right, left or both)
O	O	Heart Condition	O	O	Sexually Transmitted Disease
O	O	Tetralogy of Fallot	O	O	Kidney Disease or Transplant
O	O	Rheumatic Fever or Scarlet Fever	O	O	Liver Disease or Transplant
O	O	Bruise or Bleeds Easily	O	O	Hepatitis or Jaundice,_____
O	O	Asthma or Lung Problems	O	O	Stomach/GI Disorder _____
O	O	Pneumonia, date(s) _____	O	O	Thyroid Disorder
O	O	Cancer Malignancy, Leukemia, or Lymphoma	O	O	Currently Pregnant
O	O	Diabetes (*NIDDM* or *IDDM* _____ /day)	O	O	Implanted Shunts, Pins, Screws or Rods
O	O	Seizures, Epilepsy, or Convulsions	O	O	Physical or Emotional Abuse
O	O	Fainting Spells _____	O	O	Ear Infection/Otitis Media,
O	O	User of Tobacco Products	O	O	Cleft Lip/Palate
O	O	Drug or Alcohol Abuse	O	O	Learning Disability
O	O	Emotional or Behavioral Problems	O	O	Handicaps or Disabilities _____
O	O	Diagnosed with ADD, ADHD, or Hyperactivity	O	O	Congenital Birth Defects Down Syndrome
O	O	Psychiatric Problems	O	O	Tuberculosis or Previous Positive Test
O	O	Seasonal Allergies, Hay Fever, etc	O	O	Delayed Development (Approx Age Function_____)

Is your child currently taking any medication(s)? O yes O no If so, please list

_____

Is your child currently under the care of a physician? O yes O no If so, for what_____

Is your child allergic or has ever had an adverse reaction to a specific medication? O yes O no

if so, which medication(s) _____

Parent or Legal Guardian Signature_____**Date**_____