

## **MEDICAL HISTORY UPDATE**

PLEASE PRINT			
Date			
Patient's Name			
Home Address			
•		te Zi <sub>l</sub>	o
Age Birth date	Fe	male/Male	
	MEDICAL HIS	STORY	
YES NO	YES NO		COMMENTS  (for Office Use Only)
Heart Murmur Rheumatic Fever		Hepatitis/Liver Disease	(for Office Use Only)
Asthma		Kidney Disease Diabetes	
Rheumatic Fever		Epilepsy	
Thyroid Disease		Nervous Disorder	
High Blood Pressure		Tumor, Cancer	
Lung Disease Metallic Implant, Shunts, Pins Sore Throats Tuberculosis Chicken Pox	or Bods	Cardiac Pacemaker Measles	
Sore Throats		Tonsillitis	
☐ ☐ Tuberculosis		Ear aches	
Chicken Pox		Glaucoma	
Prolonged Bleeding When Cu	t	Mumps Bad Breath	
☐ ☐ Blood Transfusion ☐ ☐ Injury to Front Teeth		Stained Teeth	
Bleeding Gums	HH	Cold Sore, Fever Blister	
☐ DRUG/FOOD ALLERGY		Women: Are you Pregnant Now?	
If yes, to what medications/foo	ods?	AIDS	
ADD /ADHD	— H	Chemical Dependency Developmentally Delayed	
ADD /ADHD Attention Deficit Disorder/		Age level patient is at	
Attention Deficit Hyperactivity	Disorder		
s the patient taking any medications? Yes	□ No □		
If so, please list the medications:			
Has the patient recently been under the care		i Posson:	
Name of Medical Doctor for above reason:		neason.	
		5 DA DEV INICODIA TION	
	RESPONSIBL	E PARTY INFORMATION ————	
Resident Parent			Marital Status
Resident ParentLast	First	Middle Initial	Marital Status
Resident ParentLast AddressStreet	First	Middle Initial  City State	Zip
Resident ParentLast AddressStreet	First	Middle Initial	Zip
Resident ParentLast  AddressStreet  Home Phone	First Work Phone	Middle Initial  City State Cell Phone	Zip
Resident ParentLast  AddressStreet  Home PhoneE-mail Address:	First Work Phone	Middle Initial  City State Cell Phone	Zip
Resident ParentLast  AddressStreet  Home Phone  E-mail Address:  Previous Address(if less than 3 yrs.)	First Work Phone	Middle Initial  City State Cell Phone	Zip
Resident ParentLast  AddressStreet  Home Phone  E-mail Address:  Previous Address(if less than 3 yrs.)S	First  Work Phone	Middle Initial  City State  Cell Phone  City State	Zip
Resident ParentLast  AddressStreet  Home Phone  E-mail Address:  Previous Address(if less than 3 yrs.)S  Social Security #	First  Work Phone  treet  Birth date	City Cell Phone City State  City State  Cell Phone State  City State  Relationship to patient	Zip
Resident ParentLast  AddressStreet  Home Phone  E-mail Address:  Previous Address(if less than 3 yrs.)S  Social Security #  Employer	First  Work Phone  treet  Birth date	Middle Initial  City State  Cell Phone  City State	Zip
Resident ParentLast  AddressStreet  Home Phone  E-mail Address:  Previous Address(if less than 3 yrs.)  Social Security #  Employer Other Parent	First  Work Phone  treet  Birth date Occupation	Middle Initial  City State Cell Phone  City State Plant State  City State  Plant State  Yrs. Employed	Zip
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