HEALTH HISTORY

Name of Patient: ______________________________ **Date:**__________________

YES	NO	
☐	☐	Is your child being treated by a physician at this time? If yes, why?__________________
☐	☐	Has your child ever been a patient in the hospital? If yes, why?__________________
☐	☐	Has your child ever received general anesthesia/sedation? If yes, why?__________________
☐	☐	Is your child allergic to anything? (medicines, foods) If yes, what?__________________
☐	☐	Is your child taking any medicines at this time? If yes, what?__________________
☐	☐	Has your child ever had a blood transfusion? __________________

Has this child ever been treated for any of the following?

Yes	No		Yes	No	
☐	☐	Blood/circulatory	☐	☐	Gastrointestinal/stomach
☐	☐	Bones	☐	☐	Kidney/Bladder
☐	☐	Endocrine Glands	☐	☐	Heart
☐	☐	Eyes/Ears/Nose/Throat	☐	☐	Liver
☐	☐	Respiratory/Lungs	☐	☐	Muscles
☐	☐	Nervous System	☐	☐	Skin
☐	☐	Tonsils/Adenoids			

Has this child ever been diagnosed with any of the following?

YES	NO		YES	NO	
☐	☐	AIDS (HIV)	☐	☐	Leukemia
☐	☐	Anemia	☐	☐	Measles
☐	☐	Allergies	☐	☐	Intellectual Disability
☐	☐	Arthritis	☐	☐	Mumps
☐	☐	Asthma	☐	☐	Mouth Breathing
☐	☐	Autism	☐	☐	Nutritional Deficiency
☐	☐	Brain Injury	☐	☐	Orthopedic Problems
☐	☐	Bronchitis	☐	☐	Pneumonia
☐	☐	Cancer	☐	☐	Polio
☐	☐	Cerebral Palsy	☐	☐	Psychiatric Disorder
☐	☐	Chicken Pox	☐	☐	Rheumatic Fever
☐	☐	Cleft Lip/Palate	☐	☐	Scarlet Fever
☐	☐	Convulsions/Seizures	☐	☐	Scoliosis
☐	☐	Diabetes	☐	☐	Sickle Cell Anemia
☐	☐	Diphtheria	☐	☐	Sinus Problems
☐	☐	Epilepsy	☐	☐	Snoring at Night
☐	☐	Eye Problems	☐	☐	Sore Throats, Frequently
☐	☐	Excessive Bleeding	☐	☐	Spina Bifida
☐	☐	Fainting	☐	☐	Syndrome
☐	☐	Hearing Loss	☐	☐	Tetanus
☐	☐	Heart Disease	☐	☐	Tuberculosis
☐	☐	Hemophilia	☐	☐	Venerial Disease
☐	☐	Hepatitis, Type ________	☐	☐	Whopping Cough
☐	☐	Jaundice	☐	☐	Other __________________

Is there anything else you feel we need to know about your child? __________________

I certify that I have read and understand the above questions. I will not hold Dr. Brinton or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

______________________________ ____________________ ______________

Signature of person completing form | Relationship to child | Date