Link the Valley

MEDICAL HISTORY FORM FOR KIDS 12 AND UNDER

TODAY'S DATE_______________________________

NAME____________________________________ DATE OF BIRTH________________ AGE____ M__F__

ADDRESS____ PHONE #_____________________________

____ SS#______________________________

FAMILY PHYSICIAN'S NAME/ADDRESS____

____

INSURANCE COMPANY NAME_________________________________POLICY ID#______________________

POLICY HOLDER'S NAME_________________________________ POLICY HOLDER'S SS#_________________

POLICY HOLDER'S RELATIONSHIP TO PATIENT____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 2 YEARS?_________ IF YES, PLEASE EXPLAIN
____ DO YOU BLEED EXCESSIVELY WHEN CUT? Y or N

WHICH PRESCRIPTION AND/OR NON-PRESCRIPTION MEDICATIONS ARE YOU CURRENTLY TAKING?____

PLEASE "X" ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE OR HAVE HAD:

____HEART DISEASE	____BLEEDING TENDENCIES	____ANXIETY
____RHEUMATIC FEVER	____DIABETES	____STROKE
____HEART MURMUR	____TUMOR HISTORY	____RADIATION TREATMENT
____EPILEPSY	____LIVER DISEASE	____BLOOD DISEASE
____KIDNEY DISEASE	____ASTHMA	____SHORTNESS OF BREATH
____ADD/ADHD	____AUTISM SPECTRUM	____CANCER
____SEIZURES	____ULCERS	

ARE YOU ALLERGIC TO: PENICILLIN__________LOCALANESTHETICS________________________________

-ANTIBIOTICS (PLEASE LIST)____

-ANY OTHER DRUG ALLERGIES OR
SENSITIVITIES____

PRESENT DENTAL PROBLEMS?____

PATIENT SIGNATURE ____
(PARENT/ GUARDIAN for MINOR)
Please do not leave anything blank. If nothing is applicable, please write N/A.