Patient Name: _____ Age: _____ Date: _____

MEDICAL HISTORY UPDATE

1. Medical conditions: Does your child have any history of the following? *(Check all that apply)*

General Conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning
- ☐ ADHD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior Issues: Type: _____
- ☐ Emotional Disability: Type: _____
- ☐ Learning Disability: Type: _____
- ☐ Psychiatric Disorder: Type: _____

Developmental
- ☐ Brain Injury
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Developmental Delay
- ☐ Feeding/Eating Problems
- ☐ Growth Problems
- ☐ Hearing Loss: Type: _____
- ☐ Neuromuscular Defect
- ☐ Orthopedic Problems
- ☐ Seizures: Type: _____
- ☐ Speech Problem: Type: _____
- ☐ Spina Bifida

Hematological (Blood-Related)
- ☐ Anemia
- ☐ Bleeding (Prolonged)
- ☐ Hemophilia
- ☐ Sickle Cell Trait
- ☐ Sickle Cell Disease
- ☐ Transfusion of Blood

Infectious
- ☐ Hepatitis
- ☐ HIV Infection (AIDS)
- ☐ Tuberculosis

Substance Use/Abuse
- ☐ Drug Use
- ☐ Tobacco Use
- ☐ Abuse (Physical or Sexual)

Other
- ☐ Cancer: Type: _____
- ☐ Leukemia: Type: _____
- ☐ Fainting/Headaches (often)
- ☐ Sleep Apnea
- ☐ Sleep Problems
- ☐ Snoring
- ☐ Syndrome: Type: _____
- ☐ Other: _____

If any boxes checked, please describe further: _____

_____

3. Medications: Is your child CURRENTLY taking any medications?

Drug	How Much and How Often?	Reason

4. Steroid Use: Has your child had any steroid treatment in the past 6 months? ..... ☐ Yes ☐ No

5. Allergies: Has your child had any allergic reactions to:

Medications or drugs? _____

Latex? _____

Foods? _____

Other? _____

Signature: _____ **Relationship:** _____

Reviewed by: _____ Date: _____