

BIRTH HISTORY

Hospital _____ Obstetrician _____
 Type of delivery _____ Complications _____
 Birth Weight _____ Birth Length _____ Discharge Weight _____
 Did baby have any problems at or immediately after birth? _____
 List Age _____ Cooed or laughed _____ Sat _____ First Word _____ Held Head Up _____ Walked _____ Toilet Trained _____

HEALTH HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____
 Date of last physical examination _____ Results _____
 Is Minor/Child under care of physician now? YES NO Medications _____
 Receiving any medication or drugs? YES NO _____
 Has your child been hospitalized? YES NO _____

Date	Reason	Hospital

 Allergies _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/> A.I.D.S./H.I.V.	<input type="checkbox"/>	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/> Heart Problems	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Constipation, Diarrhea	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Convulsions	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Speech Problems
<input type="checkbox"/>	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/> Birth Defects	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/> Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/> Ear Infections	<input type="checkbox"/>	<input type="checkbox"/> Measles	<input type="checkbox"/>	<input type="checkbox"/> Urinary Diseases
<input type="checkbox"/>	<input type="checkbox"/> Bleeding, excessive	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/> Vision Problems
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> Mumps	<input type="checkbox"/>	<input type="checkbox"/> Worms
<input type="checkbox"/>	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia	<input type="checkbox"/>	<input type="checkbox"/> Other

IMMUNIZATIONS

Check (✓) whether or not your minor/child has been given the following immunizations. If yes, please fill in the date given.

<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DATE
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	DPT Series of 3 shots	<input type="checkbox"/>	<input type="checkbox"/>	Polio by mouth, series of 3	<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria Tetanus
<input type="checkbox"/>	<input type="checkbox"/>	DPT Booster shots	<input type="checkbox"/>	<input type="checkbox"/>	Measles Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculin Test
<input type="checkbox"/>	<input type="checkbox"/>	Polio Shots series of 3	<input type="checkbox"/>	<input type="checkbox"/>	Mumps Vaccine	Result _____		
<input type="checkbox"/>	<input type="checkbox"/>	Polio Booster Shots	<input type="checkbox"/>	<input type="checkbox"/>	Rubella Vaccine	_____		

RELEASE AND ASSIGNMENT

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with _____ Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/Guardian

Date