NEW PATIENT - HEALTH BACKGROUND

Childs Name: _____ Date: _____

Date of Birth: _____

Does the child have any chronic health problems? (Please List)

_____

_____

_____

Allergies ? (Please list, Including Asthma, Hay / Fever, Food and Medication Allergies).

_____

_____

_____

Has the child ever been hospitalized? (Please list reason and appropriate date).

_____

_____

Yes	No	
❑	❑	Is the child on medication all the time?
❑	❑	Is the child on a special diet?
❑	❑	Has he / she had any surgery?
❑	❑	Does the child have any developmental delay?
❑	❑	Is there a family history of any diseases or genetic problems or require special education?
❑	❑	Was your house / apartment built before 1960?
❑	❑	Are you on a (flouridated) City water supply?
❑	❑	Does the child participate in organized sports?
❑	❑	Are there any serious behavioral problems?
❑	❑	Do you have any major concerns?
❑	❑	Are immunizations up to date?
❑	❑	Has child had Chicken Pox?