**MEDICAL HISTORY UPDATE**

**Patient Name:** _____ _____
First Middle Initial Last Nickname

**Date of Birth:** _____ **Age:** _____ **Gender:** Male/Female

**Signature of Person Completing Form:** _____ **Date:**_____

**MARK YES OR NO TO EACH:**

Yes No ADD/ADHD, If yes, is patient taking medication? Name of medicine _____
Yes No Asthma/Breathing Issues
Yes No Autism Spectrum
Yes No Sensory Integration Issues
Yes No Seasonal allergies
Yes No Nervous or Emotional Disorders
Yes No Eating Disorders
Yes No Food Allergies (if yes, please list)
_____
Yes No Mental/Emotional Problems
Yes No Heart Trouble or Heart Murmur
Yes No Rheumatic Fever or Heart Disease
Yes No Blood Disease or Anemia
Yes No Hemophilia/Von Willebrand
Yes No Abnormal Bleeding or Bruising
Yes No Prolonged Bleeding or Transfusion
Yes No High or Low Blood Pressure
Yes No Allergic to any Medications (If yes please list) _____

Yes No Cancer, Tumors, Growths or Cysts
Yes No Steroid Therapy or Chemotherapy
Yes No Diabetes
Yes No Kidney Disease
Yes No Liver Disease
Yes No Hepatitis or Jaundice
Yes No Thyroid Disease
Yes No HIV or AIDS
Yes No Herpes virus or Shingles
Yes No Latex Allergy/Sensitivity
Yes No Birth Defect(s)
Yes No Cleft Lip or Palate
Yes No Cerebral Palsy
Yes No Down Syndrome
Yes No Developmental Delay
Yes No Physical Disability
Yes No Crohn's Disease
Yes No Any surgeries or hospital stays since your last visit, if so please list.
_____

Yes No Tuberculosis or TB Exposure
Yes No Frequent Diarrhea or Vomiting
Yes No Eye, Ear, Nose, Throat Trouble
Yes No Sinus Problems or Drainage
Yes No Hearing or Vision Impairment
Yes No Epilepsy/ Convulsions/Seizures
Date of Last Seizure:_____
Yes No Problems with anesthesia
Yes No Mumps/Measles/Chickenpox
Yes No Scarlet Fever/High Fever
Yes No Stomach Ulcers
Yes No Pregnant
Yes No Other_____
Medication currently taking:
_____
_____