



Name _____ Age _____ Birthdate _____
 Residence Address _____ City _____ State _____ Zip _____
 Patient Employed By _____ Present Position _____ Social Security # _____
 Father's Name _____ Mother's Name _____
 Father Employed By _____ How long? _____ Home Phone _____ Business Phone _____
 Mother Employed By _____ How long? _____ Home Phone _____ Business Phone _____
 Father's Social Security # _____ Mother's Social Security # _____
 Person Financially Responsible _____ Relationship to Child _____
 Address _____ City _____ State _____ Zip _____
 Whom may we thank for referring you? _____ Address _____
 What is your favorite sport? _____ Favorite hobby? _____
 Favorite music? _____ Favorite school subject? _____
 School _____ Grade _____

MEDICAL HISTORY

Physician's Name and Address _____
 Date of last physical exam _____ Physician's Phone Number _____
 List any medications you are currently taking including birth control pills: _____

Do you have or have you had any of the following? Please indicate with a check mark:

- | | | |
|--|--|---|
| <input type="checkbox"/> Any Allergies to: | <input type="checkbox"/> Anemia | <input type="checkbox"/> Measles |
| <input type="checkbox"/> antibiotics | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> anesthetics | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> environmental | <input type="checkbox"/> Asthma | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> pain medications | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Any Heart Problems: | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> Fainting | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> valve replacement | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |
| | <input type="checkbox"/> Low/High Blood Pressure | <input type="checkbox"/> Ulcer |
| | <input type="checkbox"/> Malignancies | |

Do you use tobacco? Yes No cigarette cigar pipe smokeless
 Are you pregnant? Yes No What month? _____ Obstetrician _____ Phone _____

Your Signature _____ Date _____
 Signature of Parent _____ Date _____