

Health History Update

Please update your child's health information since their last check up.



_____ Date _____

_____ Patient Name _____ Pref. Pronouns _____

_____ Who is accompanying the child today? _____ Relationship _____

Yes No **Is the patient taking any medications?**
 If yes, please list the names and dosages: _____

Yes No **Does the patient have any allergies to medications, latex or food?**
 If yes, please list: _____

Yes No **Has the patient been hospitalized for any reason?**
 If yes, please explain: _____

Yes No **Are there any new significant health changes we need to be aware of?**
 If yes, please explain: _____

Yes No **Has your child had a fever in the last 24 hours?**
 If yes, please explain: _____

_____ Parent Name Printed _____ Parent Signature _____

_____ Team member's Initials _____

PLEASE ASSIST US IN FOLLOWING HIPAA / OSHA REGULATIONS BY NOT USING PHONES / CAMERAS OR EATING / DRINKING IN OUR OFFICE - THANK YOU FOR YOUR COOPERATION!

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