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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