

Health History Update Form

Child's Name _____

Child's Birthdate ____/____/____

Name of Child's School _____

Home Address _____

Parent's Email _____

Phones _____

Home _____

Mom's Work _____

Mom's Cell _____

Dad's Work _____

Dad's Cell _____

Parent's Address *(if different from above address)*

Insurance _____

Phone _____

ID# _____ Group# _____

Employer _____

Subscriber Name _____

Subscriber Birthdate _____

Subscriber SSN _____

Has the child ever had any of the following conditions?

- Y N Developmental Delays
- Y N Current w/ Immunizations?
- Y N Abnormal Bleeding
- Y N Tuberculosis
- Y N Handicaps/Disabilities
- Y N Asthma
- Y N Allergies to any Drugs
- Y N Hepatitis
- Y N Hearing Impairment
- Y N Cancer
- Y N Sight Impairment
- Y N HIV + / AIDS
- Y N Diabetes / Endocrine
- Y N Pregnancy
- Y N Heart Disease / Murmur
- Y N Abnormal Blood Pressure
- Y N Seizures/Fainting
- Y N Any Operations / Surgery
- Y N Hemophilia/Blood disorder
- Y N Congenital Birth Defects
- Y N Kidney/Liver Conditions
- Y N Convulsions/Epilepsy
- Y N Rheumatic/Scarlet Fever
- Y N Allergies to Latex Product
- Y N Sickle Cell Trait/Disease

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent or Guardian

Date