PEDIATRIC HEALTH HISTORY FORM (CONFIDENTIAL)

Name_____ Birth Date_____
Last First

Address _____
Street

_____
City State Zip

Tel # (Home)_____ (Cell)_____ Email_____

Sex Male Female Height_____ Weight _____lbs.

Emergency Contact Name_____ Phone Number_____

If you are completing this form for another person, what is your relationship to that person?

For the following questions, circle **YES** or **NO**.

1. Please describe your child's current physical health?.....EXCELLENT GOOD POOR
2. My child's last complete physical exam was on _____
3. Is your child now under the care of a physician?.....YES NO

If yes, what is the condition being treated? _____

4. Physician's Name_____ Phone Number_____
5. Has your child had any illness or operation that required hospitalization?.....YES NO

If so, what was the illness or operation? _____

6. Please list all medications your child is currently taking_____

_____

7. Please list all allergies to medication, latex, or food_____
8. Date of last cold, cough, or fever_____
9. Please describe your child's physical activity_____
10. Does your child snore at night?.....YES NO
11. Has your child or a close relative ever had a bad reaction to any anesthetic drug?.....YES NO
12. Have you ever had complications during a previous anesthetic?..... YES NO

Does your child have or had any of the following diseases or problems? PLEASE CIRCLE

Y	N	Heart Defects/Heart Murmur	Y	N	Asthma/Bronchitis/Lung Problems
Y	N	Hepatitis/ Liver Problems	Y	N	Kidney Problems
Y	N	Bleeding Problems	Y	N	Diabetes
Y	N	Seizures/Epilepsy /Fainting Spells	Y	N	Handicaps/Disabilities
Y	N	Cerebral Palsy	Y	N	Developmentally Delayed
Y	N	Cancer	Y	N	Hearing Impairments
Y	N	Tuberculosis			

The information on this questionnaire is accurate to the best of my knowledge and that withholding any information could result in injury or death. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Jinsoo Kim of any changes in my medical status at the earliest possible time.

_____

Signature of Patient/Parent **Date**

_____

Reviewed by: Jinsoo Kim, DDS Date