UPDATE HISTORY & PHYSICAL: Complete each time a returning patient is seen.

Date: ______________________ Pt. prefers to be called ______________________

Patient Name: ______________________
Date of Birth: ______________________ Social Security # ______________________
Parent's Name: ______________________
Residence Address: ______________________
City: ______________________ STATE: __________ ZIP CODE : __________
Telephone: Home ( ) ______________________ Telephone Business ( ) ______________________
(E-mail) ______________________ Cell # ( ) ______________________
Subscriber Employer: ______________________ Position: ______________________
Nearest relative not living with you? ______________________
Contact name in case of emergency ______________________ Telephone: ______________________
Person responsible for payment of account: Name ______________________

Is your child currently taking any medications? __________ List: ______________________

Does your child have any allergies to any medications? Explain: ______________________

Is this an emergency visit? __________ Is your child having a dental problem? ______________________

Does your child have a newly diagnosed "syndrome?" _____ Specify ______________________
If your child has a diagnosed syndrome, we have to have a copy of the diagnosis from the physician on file.

Does your child have or has your child ever had any of the following conditions?

Anemia
Asthma
Autism
Birth Defects
Bleeding Problems
Blood Disorders
Blood Transfusions
Cancer
Cerebral Palsy
Chronic Ear Infections
Cystic Fibrosis
Delayed Speech
Development
Developmental Delay
Diabetes
Down's Syndrome
Emotional Problems
Epilepsy
G-Tube Feeding
Hearing Loss/
Impairment
Heart Condition/Murmur
Hepatitis
Herpes
High Blood Pressure

HIV/AIDS
Hyperactivity/ADHD
Kidney Disease
Learning Disabilities
Liver Disease
Mental Retardation
Muscular Dystrophy
Pregnant
Psychiatric Problems
Radiation Therapy
Rheumatic Fever
Seizures
Sexually Transmitted Disease
Sickle Cell Anemia
Skin Disorders
Sleep Apnea
Snoring
Spina Bifida
Tuberculosis
Tumors
X-ray Treatment (not dental)
List Food Allergies: __________
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______________________ ______________________
Signature of Patient--Parent/Guardian (if minor) Date