

## Patient Yearly Update

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Person with Patient Today \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Email Address \_\_\_\_\_

Any Change in Address  Y  N If Yes, \_\_\_\_\_

Any Change in Insurance  Y  N If Yes, \_\_\_\_\_

Do You Have Any Concerns for the Doctor Today? \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone # \_\_\_\_\_

Date of last visit to physician: \_\_\_\_\_

Is the child currently under the care of a physician?  Yes  No

Please describe the child's current health:  Good  Fair  Poor

Please list all drugs that the child is currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Are your child's immunizations up to date?  Yes  No

Does your child have any drug allergies?  Yes  No

If yes, please list \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is your child allergic to latex? (Balloons, Band-aids, Bananas)

Yes  No

Has the child ever had any unhappy dental visits?  Yes  No

Is the child's water fluoridated?  Yes  No

Is the child taking Fluoridated supplements?  Yes  No

Does the child brush his/her teeth daily?  Yes  No

Please list any previous hospitalizations/surgeries/serious illnesses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PLEASE MARK IF YOUR CHILD HAS EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

	YES	NO		YES	NO
Abnormal Bleeding/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Any Hospital Stays/Operations	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve/Joint	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Cleft lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Rhematic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Emotion, Mental, Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>
Handicaps/Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Any Syndromes	<input type="checkbox"/>	<input type="checkbox"/>

### IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE GIVE A BRIEF EXPLANATION

\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_

SIGNATURE OF PARENT OR LEGAL GUARDIAN