

Patient Name: _____ Date of Birth: _____

PEDIATRIC ASSOCIATES, P.A.
Pensacola * Pace * Perdido
SCHOOL CHILD INITIAL HEALTH HISTORY
(AGE 5 AND UP)

Birthplace (City & Hospital): _____ Birth Weight: _____
As your child has grown up, has he/she been different from other children in any apparent way? If so, please describe: _____

Describe any accidents requiring a doctor's care: _____

Hospitalizations? Describe giving name of hospital, date, reason: _____

Surgeries or stitches? Please list when and location: _____

Medication currently in use? Please give name, amount and dose interval: _____

Allergies? (Substance/Reaction) Describe: _____

Who lives in your home? _____

Do you have pets? Yes / No

Does anyone smoke inside? Outside? Please circle or circle "No"

Does your child participate in team/individual sports? _____

Name of School: _____ Grade: _____

Academic performance : Below Average - Average - Above Average

Any difficulties in school? If so, please describe: _____

Age at onset of menstruation: _____ How many days does the cycle last? _____

Have you observed any developmental delays compared to other children at your child's age? Yes / No. If yes, describe: _____

FAMILY TRAITS : Please circle any of the following conditions shared by a **blood relative** of this child:

Any Brain Disorder	Convulsions/Seizures	School Learning difficulty	Asthma
Attention Deficit Disorder	Cystic Fibrosis	Heart Defect since Birth	Eczema
High Blood Pressure (< age 50)	High Cholesterol	Irritable Bowel Syndrome	Suicide
Stomach/Intestinal Ulcer	Ulcerative Colitis	Thyroid Disorder/Goiter	
Diabetes requiring Insulin	Polycystic Kidney Disease		
Kidney Stones	Anemia (low blood)	Sickle Cell	
Hemoglobin C	Hemophilia (free bleeder)		
Thalassemia	Depression	Violent Behavior	
Drinking Problem	Bipolar disorder	Schizophrenia	

Any long term condition requiring ongoing medical care? _____
or death prior to age 40?