



Pediatric Associates
of Jacksonville
Dr. O.

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CONFIDENTIAL PATIENT HEALTH PROFILE

Patient Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Name of person completing form

Relationship to patient

PAST MEDICAL HISTORY

(PLEASE CHECK MEDICAL PROBLEMS THAT YOUR CHILD HAS HAD IN THE PAST)

- | | | |
|---|---|--|
| <input type="checkbox"/> BLADDER INFECTION | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> CHICKEN POX (Age/Yr: _____) |
| <input type="checkbox"/> KIDNEY INFECTIONS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> MEASLES |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> SINUSITIS | <input type="checkbox"/> T.B. |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> TONSILLITIS | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SICKLE CELL |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HERPES | <input type="checkbox"/> SMOKING |
| <input type="checkbox"/> SEIZURES/STROKES | <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> GLASSES/CONTACT LENS | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> AGE AT MENSTRUATION (if applicable) |
| <input type="checkbox"/> FRACTURES: Provide child's age and location of break(s): _____ | | |

LIST ALL SURGERIES: (Please indicate child's age at time of surgery)

OTHER MEDICAL PROBLEMS: _____

DEVELOPMENT & GROWTH: WNL Y / N If no, please explain: _____

MENTAL HEALTH STATUS: Normal for age Y / N If no, explain: _____

RELAVENT FAMILY HISTORY: _____

ALLERGIES TO MEDICINES: YES NO (LIST IF APPLICABLE)

ALLERGIES TO OTHER: YES NO (LIST IF APPLICABLE)

MEDICATIONS

Previously taken: _____

Currently taking: _____

Parent/Guardian Signature

Reviewed by: Name & Title