



PUNTACANA®
INTERNATIONAL SCHOOL

Clinical History
2017-2018

Students Name: _____ Date of birth: _____

Gynecological-Obstetrical Background

Weeks of pregnancy at the moment of delivery: _____

Childbirth: Delivery _____ C- Section _____

Total Number of Children: _____ Child Number: _____

Did your child receive antibiotics? Yes _____ No _____ Please Specify _____

Is your child under any medical treatment? Yes _____ No _____ Please Specify _____

Childhood diseases

Has your child suffered from any of these diseases?

Measles _____ Rubella _____ Chicken pox _____ Mumps _____

Is the vaccination schedule complete for your child's age? Yes _____ No _____

Allergy History

Allergy to any medicines Yes _____ No _____

If your answer is yes, which of these?

Aspirin _____ N-Buyil _____ Penicillin _____ Ampicilin _____

Ibuprofen _____ Cryopressin _____ Dipyron _____ Diclofenac _____

Is there a history of allergies in the family? Yes _____ No _____

If your answer is yes, ¿who and to what? _____

Has your child suffered any accidents? Yes _____ No _____

Please specify: _____

Surgical History

Has your child ever been surgically intervened? Yes _____ No _____

If your answer is yes, please specify? _____

Has your child ever received a blood transfusion? Yes _____ No _____

Does your child suffer from any diseases?

Asma _____ Falcemia _____ Leukemia _____ Epilepsy _____ Tonsillitis _____

Others: _____