OAK PARK PEDIATRICS LTD

Pediatric Health History Form

Child's Name: _____**Birthdate:** _____

Child's Previous doctor: _____

Child's Dentist:_____ Regular Visits? Yes No

Your Regular Pharmacy (Name/Street): _____

Current Problems/Concerns:

_____

_____

Allergies/Reactions to Medicines, Foods, or Environment (Please list nature of reaction:)

_____

Current Medicines:

_____

Pregnancy & Birth:
Were there any problems with the pregnancy?
___No ___Yes (please specify:) _____

Was the baby full term _____ or premature? _____ if so, how early?_____

Delivered by: ____vaginal birth ____caesarian (please explain why:) _____

Birth weight: _____Birth length: _____ Passed Hearing Screen ___Yes___No

Delivery Hospital:_____ Your Ob: _____

Past Medical History:
Has your child had any of the following conditions? Please circle all that apply:

Asthma / hay fever / eczema	RSV/Bronchiolitis	Pneumonia
Attention/Learning problems	Seizures/convulsions	Developmental delays
Broken bones/major injuries	Anemia/Bleeding problems	Urinary tract infections
Heart problem or murmur	Chicken pox	Other
Frequent ear infections	Frequent strep infections	_____

Past Surgical History:
Has your child had any operations such as ear tubes, hernia repair, or tonsillectomy?
_____No _____Yes (Please explain- type of surgery, location, dates):

_____

Immunizations: ***Please bring your child's shot record.***
Are your child's immunizations up to date? ___Yes ____No

Social History/ Safety Issues:

The child's parents are: ____married ____ single
____divorced ____ other (specify)_____
Who lives in the home? _____

Does your child attend daycare during the day or after school? ____Yes ___ No

Do any household members smoke? ____ Yes ___No
Do you have a gun in your home? ___Yes ___No Are they locked up? ___Yes ___No

Any concerns about lead exposure? (old home/plumbing/peeling paint) ___Yes ___No
Has your child had a previous lead test? ___Yes ____No
If so, was it normal or low? ____ Yes ____No

Does your child attend preschool/school? ____Yes ___No Grade: _____
Name of School: _____
Any concerns about school performance? ____ Yes ___No
(specify:)_____

Are there any pets in your home? ____Yes ____No (specify:) _____

Family History:
Please circle any family history of the following and indicate who has/had the condition (mother, father, brother, sister, maternal/paternal grandparent, extended family):

Alcoholism	Yes/No_____
Attention Deficit Hyperactivity Disorder	Yes/No_____
Asthma	Yes/No_____
Allergies/hay fever	Yes/No_____
Bleeding / clotting problems	Yes/No_____
Cancer (specify type of cancer)	Yes/No_____
Depression	Yes/No_____
Diabetes (specify Type 1/ Type 2)	Yes/No_____
Drug abuse	Yes/No_____
Eczema	Yes/No_____
Heart disease	Yes/No_____
Heart attack (before age 50)	Yes/No_____
Hearing Loss/Deafness	Yes/No_____
High blood pressure (before age 50)	Yes/No_____
High cholesterol	Yes/No_____
Hip problems/dislocations	Yes/No_____
Inherited/ genetic diseases/ birth defects	Yes/No specify:_____
Kidney Disease	Yes/No_____
Learning Disabilities	Yes/No_____
Mental illness/anxiety	Yes/No specify:_____
Seizures/febrile seizures	Yes/No_____
SIDS	Yes/No_____
Sudden unexplained death before age 50	Yes/No_____
Thyroid disease	Yes/No specify: _____
Other (please explain)	Yes/No_____

How did you hear about Oak Park Pediatrics? _____