



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? _____