OakLeaf PEDIATRICS

Health History

Child's Name: _____Today's Date: _____

Child's Birthdate: _____ Female Male Name of School & Grade _____

Address: _____
(Street) (City) (State) (Zip Code)

Emergency Contact Name: _____ Phone: _____

Relationship to child: _____

Parent Information

Father's Name: _____ Date of Birth_____

Occupation: _____ Place of Employment: _____

Home phone: _____ Work phone: _____

Mother's Name: _____ Date of Birth: _____

Occupation: _____ Place of Employment: _____

Home phone: _____ Work phone: _____

Are Parents: ☐ Married ☐ Divorced ☐ Separated

Please list the names and relationships of anyone else involved in the child's care: _____

_____

Family History

Names and birthdates of siblings: _____

_____

Family Health History: Does anyone in your family suffer from:

Condition	Yes	No	Who has this condition (Relationship to Child)
Heart Disease			
High Blood Pressure			
Alcoholism			
Allergies			
Depression			
Diabetes			
Thyroid Disorder			
Cancer			
Asthma			
High cholesterol			

Newborn History

(Please fill out if child is less than 5 years of age)

Birth weight: _____ **Method of Delivery:** Vaginal C-Section Forceps/Vacuum

Length of pregnancy: _____weeks **Feeding**: Breast Bottle Both

Problems during pregnancy or delivery: _____

While in the hospital, did the child have any of the following?:

Condition	Y	N	Condition	Y	N
Jaundice			Infection		
Poor Feeding			Breathing Concerns		

Other concerns during hospital stay:

_____

_____

Did mother and child leave the hospital together? If no, please explain: _____

_____

Health History

Please list all current medications: _____

_____

Has your child been immunized? ☐ Yes ☐ No At what clinic: _____

Did this person have, or does this person now have any of the following:

Condition	Y	N	Date	Condition	Y	N	Date
Frequent Colds/Infections				Chronic Cough			
Easy bruising or bleeding				Wheezing or Asthma			
Loss of consciousness				Poor appetite			
Head Injury				Weight loss			
Seizure or convulsion				Heart murmur			
Frequent headaches				Bloody stool			
Eye problems				Blood in urine			
Recurrent ear infections				Swollen joints			
Hearing problems				Frequent falling			
Constipation				Dental cavities			
Chronic vomiting or diarrhea				Skin problems			
Frequent stomach aches				Ingestion of poison			
Bladder/Kidney problem				Chicken pox			
Meningitis				Whooping cough			

Does your child have allergies (food, medication, etc.)? If yes, explain: _____

_____

Has your child had any hospitalizations, operations or major illnesses? If yes, explain: _____

_____