Northern Oklahoma Regional Pediatric Clinic History Form revised 10/2013

Patient History Form

Patient Name_____ Date of Birth_____

Pregnancy/Birth Information:

Did mother have any complications during pregnancy? (i.e. diabetes, thyroid, preeclampsia) YES NO (please circle one)
If yes please explain: _____
Did mother have any complications during delivery? YES NO (please circle one)
If yes please explain:_____
C-Section or Vaginal Delivery (please circle one) Birth Weight: _____ Length:_____
Full term pregnancy (38 weeks or more)? YES NO (please circle one) If not, how many weeks premature? _____
Did the baby have any medical problems at the time of birth or special needs? YES NO (please circle one)
If yes please explain: _____

Past Medical History:

Has patient had any allergic reaction to any medications, foods or insect bites? YES NO (please circle one)
If yes please explain: _____
Has patient had a bad /allergic reaction to any immunizations? YES NO (please circle one)
If yes, which ones: _____
Any hospitalizations/surgeries? YES NO (please circle one)
If yes please explain: _____
Any serious injuries/broken bones/stitches? YES NO (please circle one)
If yes please explain: _____
Any chronic illness/infectious disease/birth defect? YES NO (please circle one)
If yes please explain: _____
Has the patient seen a dentist? YES NO (please circle one) Date of last dental appt? _____

REVIEW OF SYSTEMS	YES	NO
Does patient have any hearing or vision problems? (Circle which are yes)		
Has patient had frequent ear infections?		
Does patient have a history of allergies, asthma, pneumonia or recurrent cough? (Circle which are yes)		
Does patient have a heart murmur or any heart problems?		
Any problems with kidneys, bladder or urination?		
Any problems with diarrhea or constipation?		
Any eczema, hives or other skin conditions?		

Family History: **P-Patient M – Mother F – Father S – Sibling FH – Family History**

DISEASES/DISORDERS	P	M	F	S	FH	DISEASES/DISORDERS	P	M	F	S	FH
Alcohol/drug abuse (ETOH)						Bleeding/clotting problems					
Heart Disease/stroke (CAD)						Kidney disease					
Cancer (CA)						Asthma/hay fever/allergies/eczema					
Seizures						High Blood Pressure (HTN)					
Inherited/genetic disease						Birth defects					
Thyroid disease (Hyper or Hypo)						Diabetes					
Psychiatric Disorder						High Cholesterol					

Social History:

Are the children's parents -married -unmarried -separated -divorced -widowed (please circle one)
Do any members of the household smoke? YES NO (please circle one)
Are there any concerns about lead exposure (peeling paint, plumbing, old home)? YES NO (please circle one)
Is there any of the following a concern about the patient? (Please circle one)
- Alcohol abuse - Tobacco use - Sexual activity - Aggressive behavior - None
How many hours a day does your child watch TV/play video games? _____
Other household members (name, DOB, relation):

1. _____ 4. _____ 7._____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9._____

Parent/Guarantor Signature _____ Date _____