Northern Oklahoma Regional Pediatric Clinic
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Patient Name: _____ D.O.B _____ Today's date: _____

Pregnancy/Birth History

Baby was born at ____ weeks gestation via (circle one) c-section vaginal delivery
Induced: (circle one) YES NO
Delivery was: uncomplicated complicated
If complicated please explain: _____
Pregnancy was: (circle one) uncomplicated complicated
If complicated please explain _____ _____
Mother's blood type: _____ Infant blood type (if known): _____
Did patient receive Hepatitis B vaccine at birth? (circle one) YES NO
Birth weight: _____ Discharge weight: _____

Surgical History:
Has your child ever had surgery? (circle one) YES NO
If yes please explain: _____
If male, is your child circumcised? (circle one) YES NO N/A

Family History: **Please circle all that apply to family history.**
DISEASE/DISORDER
Eye disease Ear/nose/throat/ disease Asthma/allergies/eczema Cancer: _____
Heart disease/Stroke/High BP Stomach or bowel disease Bleeding/clotting problem Neurological disorder
Psychiatric disorder Kidney disease Thyroid disease/Diabetes Immune disorder
Other: _____

Social History:
Patient lives with:(circle all that apply) Mother Father Grandmother Grandfather Foster parent Guardian: _____
Are parents alive: (circle one) YES NO If no please explain cause of death: _____
Parents married: (circle one) YES NO
Is your child in daycare?: (circle one) YES NO

Sibling name	DOB	Gender (M/F)	Cared for here? Y/N	Alive? Y/N

All school aged children:

Grade_____ (circle one) doing well having problems with _____
How many hours per day does your child spend watching TV: _____ playing video games: _____

11-18 YR old habits
Does your child use any of the following: nicotine alcohol marijuana other drugs: _____ NONE
Is your child sexually active: (circle one) YES NO

Parent/Guardian signature: _____
By signing above I agree for Northern Oklahoma Regional Clinic to pull my child's history medications for office use only.