Oklahoma Kids Pediatrics

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New Pediatric Patient History

Patient's Name:_____Date of Birth:_____

Form Completed By:_____Relationship to patient:_____

Birth History

Birth weight_____lbs_____ounces

The baby was born: ☐On Time ☐Early ☐Late

If early or late, how many weeks gestation?___weeks

Did mother have any illness or problem with her pregnancy? ☐No ☐Yes,_____

_____

During pregnancy, did mother:

☐Smoke ☐Drink Alcohol ☐Use drugs

How much?_____When?_____

Did mother take prescription medications?

☐No ☐Yes,_____

Was the delivery ☐Vaginal? ☐Cesarean?

If cesarean, why?_____

Did the baby have any problems right after birth? ☐No ☐Yes,_____

_____

_____

Did the baby have to stay in the NICU?

☐No ☐Yes because,_____

_____How long_____

Did baby go home with mother from the hospital?

hospital? ☐Yes ☐No, because_____

Medical History

Do you consider this child to be in good health? ☐Yes ☐No, because_____

_____

Please list any serious injuries or accidents:

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Please list any surgeries:

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Please list any hospitalizations not included above:

_____Date:_____

_____Date:_____

_____Date:_____

_____Date:_____

Please list any allergies:

Substance:_____Rash? ☐Yes ☐No. Life threatening reaction? ☐Yes ☐No

Substance:_____Rash? ☐Yes ☐No. Life threatening reaction? ☐Yes ☐No

Substance:_____Rash? ☐Yes ☐No. Life threatening reaction? ☐Yes ☐No

Substance:_____Rash? ☐Yes ☐No. Life threatening reaction? ☐Yes ☐No

Please list all medications this child takes regularly:

_____dose:_____frequency:_____

_____dose:_____frequency:_____

_____dose:_____frequency:_____

_____dose:_____frequency:_____

_____dose:_____frequency:_____

New Pediatric Patient History

Has this child had any of the following problems? If so, how old were they at diagnosis? Circle the problem.

	AGE		**AGE**
ADHD		Hearing problems	
Anxiety		Heart problems or murmur:	
Asthma		Hypertension(High blood pressure)	
Bedwetting or Daytime accident		Learning problems:	
Bladder or Kidney Infection		Seizures	
Concussion		Skin problems:	
Depression		Speech Problems	
Diabetes		Stroke	
Ear infections		Vision problems:	
Headaches:		Other:	

Family History

Please list all people who live with the child, their age, and any health problems. Also list any siblings or parent who do not live in the same household.

NAME	RELATIONSHIP	AGE	HEALTH PROBLEMS

Social History

Does the child live with both biological parents?☐Yes☐No-please explain:_____

_____

Does this child attend daycare or Mother's Day Out?☐No☐Yes. How often?_____

Does anyone smoke inside or outside the house?☐Yes☐No

Are there any pets?☐No☐Yes. What Kind?_____

Has there been any history of abuse?☐No☐Yes,☐physical,☐emotional☐sexual, when?_____

Has this child ever been homeless, a resident of a shelter, or group home?☐No☐Yes, when?_____

Does this child attend school?☐No☐Yes. What grade?_____Name of school_____

Homeschooled?☐No☐Yes

Any other information you would like this child's health care provider to know?_____

_____

_____

_____