

CHILDREN'S OASIS PEDIATRICS HEALTH HISTORY

NAME _____			
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RACE _____	SOCIAL SECURITY NUMBER _____	DATE OF BIRTH _____

Please list all people in the household:

NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father			
Mother			
Other			
Other			
Other			
Other			

Have there been any recent major changes or stresses in the child's life? YES NO

If YES, Explain _____

Does child go to a baby sitter, preschool or day care regularly? YES NO

BIRTH HISTORY:

Birth Weight _____ Length _____ Place _____

During the pregnancy did the mother see a doctor regularly? YES NO

During pregnancy did the mother: (If YES, Explain) _____ Explanation

Have any medical problems? YES NO _____

 Smoke or drink? YES NO _____

 Use any medications? YES NO _____

 Use alcohol or other drugs? YES NO _____

 Have problems with labor/delivery? YES NO _____

How long did the baby stay in the hospital after birth? _____

PAST MEDICAL HISTORY:

Is the child's general health: GOOD FAIR POOR _____ Explanation

Does the child have any allergies? YES NO _____

Is the child taking any medications? YES NO _____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____ Date: _____

_____ Date: _____

Has the child ever had any problems with the following. If YES, please explain.

- | | | | |
|---------------------|------------------------------|-----------------------------|-------|
| Eyes/Vision | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Feet | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Digestion/Nutrition | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Ears/Hearing | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Urine/Kidneys | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Joints | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Skin | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Lungs | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Teeth | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Heart | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Repeated Infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

FAMILY HISTORY

Have any of the child's brothers or sisters died? YES NO _____

If YES, give age and cause _____

Have any of the child's blood relatives had the following diseases? If YES, please list family member.

- | | | | |
|---------------------------|------------------------------|-----------------------------|-------|
| Heart Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Tuberculosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| High Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Kidney Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Allergies/Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Mental/Emotional Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Sickle Cell | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

DEVELOPMENT

Do you have any concerns about the following? If YES, please explain.

- | | | | |
|------------------------|------------------------------|-----------------------------|-------|
| Development | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Behavior | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Eating Habits | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Sleeping Habits | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| School Experience | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Bathroom/Toilet Habits | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Discipline | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Other (explain) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

IMMUNIZATIONS

Up to date? YES NO

Reviewed By: _____ Date: _____