owasso pediatric
& adolescent medicine

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 any 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 the baby go home with mother from 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

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Substance: __________________________ Rash? ☐ Yes ☐ No. Life-threatening reaction? ☐ Yes ☐ No

Please list all medicines this child takes regularly:

__________________________________ dose: ___________________ frequency: ________________

__________________________________ dose: ___________________ frequency: ________________

__________________________________ dose: ___________________ frequency: ________________

________________________________ dose: __________________ frequency: ______________
dose: __________________ frequency: ______________

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 accidents		Learning problems:	
Bladder or Kidney infection		Seizures	
Concussion		Skin problems:	
Depression		Speech problems:	
Diabetes		Stroke	
Ear infections		Vision problems:	
Headaches:		Other:	

Are this child's immunizations up to date? ☐ Yes ☐ No (Please provide records)

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 the house 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 physician to know? ________________________________
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