Oceans Pediatrics

Pediatric Patient History

Patient Name: _____ Date of Birth: _____ Sex: _____

Completed by: _____ Relationship to Patient: _____

Who referred you to Oceans Pediatrics: _____

Pregnancy & Birth:

Mother's age at pregnancy: _____

Hospital of birth: _____

Birth weight: _____

During pregnancy, did mother use/have (please circle all that apply):

Tobacco
Alcohol
Drugs
Hepatitis B
Group B Strep
Syphilis
HIV

Baby (please circle all that apply):

Premature
Jaundice
Breast Feeding
Birth Complications
C Section
Breathing Problems
Formula

Who resides in the home?

_____

_____

Family Medical History:

Has anyone in your immediate family been treated for (please circle all that apply):

Anemia
Asthma/Lung Disease
High Blood Pressure
Tuberculosis
Thyroid Problems
Seizures
Cystic Fibrosis
Diabetes
Heart Disease/Murmur
High Cholesterol
Kidney Disease
Other: _____

Has/does your child:

Have an allergy to medicine? _____

Have other allergies? _____

Take medication? _____

Had surgery? (age & procedure) _____

Been hospitalized? (age & reason) _____

Had serious injuries? (age and description) _____

Do you have any concerns about your child's development or behavior? _____

Does your child have any communication needs (vision impaired/ hearing impaired/ cognitive issues)?

If so: Reason: _____ Provider: _____ Phone: _____

Does your child receive therapy/counseling/ services (speech, ENT, allergy) from other providers?

If so: Reason: _____ Provider: _____ Phone: _____