CHILDREN'S OASIS PEDIATRICS
HEALTH HISTORY

Name: _____ DOB: _____

Sex ☐ Male ☐ Female Race/ethnicity: _____

PLEASE LIST ALL PEOPLE IN THE HOUSEHOLD:

Name	Date of Birth	Occupation	Education
Father			
Mother			

Have there been any recent major changes or stresses in the child's life? ☐Yes ☐No

If Yes, explain _____

Does the child go to: ☐ Daycare Center ☐ Home Daycare ☐ Relative ☐ Sitter

BIRTH HISTORY: BIRTH WEIGHT _____ LENGTH _____

Place: ☐ Chandler Regional ☐ Mercy Gilbert ☐ Banner Hospital ☐ Other

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

During the pregnancy, did mother: (if YES, please 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 or delivery? ☐ YES ☐ NO _____

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

Does the child have any allergies? ☐YES ☐ NO Explain: _____

Is the child taking any medications? ☐YES ☐ NO Explain: _____

BACKSIDE TO BE DONE

PAST MEDICAL HISTORY: Is the child's general health ☐ GOOD ☐ FAIR ☐ POOR

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

Eyes/Vision	☐ YES ☐ NO	_____
Digestion/Nutrition	☐ YES ☐ NO	_____
Ears/Hearing	☐ YES ☐ NO	_____
Urine/Kidneys	☐ YES ☐ NO	_____
Heart	☐ YES ☐ NO	_____
Lungs	☐ YES ☐ NO	_____
Skin	☐ YES ☐ NO	_____
Neurological/Seizures	☐ YES ☐ NO	_____
Joints	☐ YES ☐ NO	_____
Teeth	☐ YES ☐ NO	_____

Please list any hospitalizations, surgeries, or serious illness with age or date:

_____ Age/Date _____

_____ Age/Date _____

FAMILY HISTORY:

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

If yes, please give cause. _____

Check the box if any of the child's blood relatives had the following diseases?

	NO	Father	Mother	Paternal Grandpa	Paternal Grandma	Maternal Grandpa	Maternal Grandma	Other
Heart Disease:								
High Blood Pressure:								
Kidney Disease:								
Allergies:								
Asthma:								
Diabetes:								
Depression:								
Anxiety:								
Any Emotional or Behavioral diagnosis:								
Sickle Cell:								
Seizures:								
Cancer:								

IMMUNIZATIONS

Up to date? ☐ YES ☐ NO