Little Oaks Pediatrics
Patient Medical History

Patient Name:_____ DOB:____/____/_____

Pregnancy & Birth	Mother's Age at child's Birth:
Any problems during pregnancy? ☐ Excessive Weight Gain ☐ Diabetes ☐ UTI ☐ Pre-eclampsia (high blood pressure and protein in urine) ☐ Infection ……..	
Medication during Pregnancy? ☐ Yes ☐ No (Exclude Vitamins & Iron) If yes, what medication ? ……..	
During pregnancy did Mom ☐ Smoke ☐ Drink Alcohol ☐ Do Street Drugs	
At Birth, how many gestational weeks was your child? (e.g. term = 40 weeks) ……wks	
Type of Delivery? ☐ Vaginal ☐ Cesarean Section Birth Weight: Length:	
Problems with baby at birth? Breathing: ☐ Yes ☐ No **Jaundice:** ☐ Yes ☐ No	
Problems soon after Birth?	
Feeding: ☐ Breast Milk ☐ Formula Type of Formula:	
Feeding Problems? ☐ Colic ☐ Recurrent Vomiting ☐ Recurrent Diarrhea ☐ Multiple Formula Changes	

Past Medical History	**Allergic Reactions? Medicine:** Yes No **Food:** Yes No
Animals: Yes No **Please List:**	
Medications taken on a regular basis? (exclude vitamins):	
Hospitalizations (when-where-why):	
Serious Injuries (when-what kind) :	

Biological Parents: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Remarried
Patient primarily resides with : ☐ Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Relative ☐ Legal Guardian ☐ Child Protective Services If both parents are not living together, who has custody?
Siblings :
Does your child go to daycare or school? Yes no Where?
Does your family routinely use seatbelts or car seats ? Yes no
Guns in home? ☐ Yes ☐ No If yes, locked cabinet: ☐ Yes ☐ No
What is your drinking water source? ☐ City ☐ Well ☐ bottle water (if so, brand:) ☐ Mostly juice, sodas
Tobacco Exposure: ☐ none ☐ patient smokes ☐ household member smokes (even if outside)

Past, Present & Recurrent Illnesses

	Yes	No		Yes	No
Measles			Mumps		
Chicken Pox			Whooping Cough		
Scarlet Fever			Ear Infections		
Asthma/Wheezing			Eczema/Hives		
Anemia			Hepatitis		
Bleeding Tendency			Urinary Infections		
Blood Transfusions			Joint Problems		
German Measles			Problems Hearing		
Seizures			Problems w/vision		
Strep Throat			Other		

Family Medical History

List all blood relatives of your child who have had the following problems – use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Anemia/Blood Disorders	Allergies	ADHD	Arthritis	Aids/HIV
Asthma	Autism	Cancer	Cystic Fibrosis	Cholesterol Problems
Birth Defects	Diabetes	Eczema	Ear Tubes	Epilepsy/Seizures
Drug Problem	Early Deafness	Emotional/Behavioral Problems	Growth Problems	Heart Attack/Stroke (under 55)
Heart Disease (under 55)	High Blood Pressure	Hereditary Problems	Intellectually Challenged	Muscular Dystrophy
Migraines	Tuberculosis	School Problems	Sudden Infant Death	Other:

Signed _____ **Date**_____