OakLeaf CLINICS
PINE GROVE FAMILY MEDICINE

Pediatric Health History *age 12 and under*

Child's Name: _____Today's Date: _____

Child's Birthdate: _____ Female Male Name of School & Grade _____

Address: _____
(Street) (City) (State) (Zip Code)

Emergency Contact Name: _____ Phone: _____

Relationship to child: _____

Race: White ⊤ Asian ⊤ Native Hawaiian ⊤ Other Pacific Islander ⊤ African American ⊤ American Indian ⊤ Alaska Native ⊤ Decline

Language: English ⊤ Spanish ⊤ Hmong ⊤ Other ⊤ Decline **Ethnicity:** Not Hispanic/Latino ⊤ Hispanic/Latino ⊤ Decline

Parent Information

Father's Name: _____ Date of Birth: _____
Occupation: _____ Place of Employment: _____
Home phone: _____ Work phone: _____

Mother's Name: _____ Date of Birth: _____
Occupation: _____ Place of Employment: _____
Home phone: _____ Work phone: _____

Are Parents: Married Divorced Separated

Who else lives in the child's home? _____

Please list the names and relationships of anyone else involved in the child's care: _____

_____

Family History

Names and birthdates of siblings: _____

_____

Family Health History: Does anyone in your family suffer from?

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Alcoholism/Drug abuse				High Blood Pressure			
Allergies				High Cholesterol			
Asthma/Hay fever/Eczema				Inherited/Genetic Disease			
Birth Defects				Kidney Disease			
Bleeding/Clotting Issues				Psychiatric Disorders			

Cancer				Seizures			
Depression				Stroke/Heart Disease			
Diabetes				Thyroid Disorder			

Newborn/Infant History

(Please fill out if child is less than 5 years of age)

Birth weight: _____ Method of Delivery: Vaginal C-Section Forceps/Vacuum

Length of pregnancy: _____weeks Feeding: Breast Bottle Both

Problems during pregnancy or delivery: _____

While in the hospital, did the child have any of the following?

Condition	**Y**	**N**	**Condition**	**Y**	**N**
Jaundice			Infection		
Poor Feeding			Breathing Concerns		

Did mother and child leave the hospital together? If no, please explain: _____

_____

How many hours per night does your child sleep? _____Naps? (Number & Length) _____

Does your child have any sleep problems? If yes, explain: _____

Has your child been immunized? Yes No If yes, in WI? Yes No Other state? _____

Has your child been seen by a dentist? Yes No If yes, date of last visit_____

Does anyone in the home smoke? Yes No Has your child been exposed to lead? Yes No

Health History

Please list all current medications and supplements:

MEDICATION NAME	DOSE	FREQUENCY

Please list any allergies and reactions:

ALLERGY	**REACTION**
Non-Drug:	
Drug:	
Food/Seafood:	

Did this child have, or does this child now have any of the following?

Condition	Y	N	Date	Condition	Y	N	Date
Frequent Colds/Infections				Chronic Cough			
Easy bruising or bleeding				Wheezing or Asthma			
Loss of consciousness				Poor appetite			
Head Injury				Weight loss			
Seizure or convulsion				Heart murmur			
Frequent headaches				Bloody stool			
Eye problems				Blood in urine			
Recurrent ear infections				Swollen joints			
Hearing problems				Frequent falling			
Constipation				Dental cavities			
Chronic vomiting or diarrhea				Skin problems			
Frequent stomach aches				Ingestion of poison			
Bladder/Kidney problem				Chicken pox			
Meningitis				Whooping cough			

Please list any previous hospitalizations or surgeries:

PREVIOUS HOSPITALIZATIONS	PREVIOUS SURGERIES

Concerns about your child: Alcohol use Tobacco use Sexual Activity Aggressive behavior

Is violence at home a concern? Yes No If yes, explain: _____

Girls only: Age of first menstrual period? _____

Current grade? _____ Name of school? _____

Sports/exercise. Type? _____ How often/minutes per day? _____

How many hours per day does your child do the following?

Watch TV _____Computer _____ Video Games _____

Any other major illness? If yes, explain: _____

_____

Thank you for choosing our office, we look forward to caring for your child.