OVIEDO CHILDREN'S HEALTH CENTER ***Patient History Form***

Patient Name: _____Date of Birth: _____/ _____/ _____
Birth Weight: _____ lbs _____oz Delivery: (Circle One) Vaginal or Cesarean Section

PREGNANCY & BIRTH HISTORY

1. Did mother have any illnesses or problems during pregnancy ..... Y / N
2. Did mother take any drugs or medications during pregnancy other than iron or Vitamins ..... Y / N
   a. If yes, what _____
3. Did mother drink **ANY** form of alcohol during pregnancy ..... Y / N
4. Were there any **ABNORMAL** tests during pregnancy (blood tests, ultrasounds, etc.) ..... Y / N
5. Did the baby arrive (Circle One) Early or Late
   a. If late how many days or weeks _____
6. Were there any problems at the delivery ..... Y / N
7. Did the baby have any problems (breathing problems, jaundice, cyanosis, etc) ..... Y / N
   a. If yes, explain _____

PATIENT'S PAST HISTORY

8. At what age did your child -
   ROLL OVER _____ SIT _____ STAND _____ WALK _____ START TALKING _____ TOILET TRAINED _____
9. Has your child had more than four (4) ear infections ..... Y / N
10. Does your child usually have more than five (5) colds or sore throats each year ..... Y / N
11. Does your child usually get an ear infection after a cold ..... Y / N
12. Does your child seem to have a continuous "stuffy" nose or constant cold ..... Y / N
13. Has your child had "asthma" or "wheezing" more than two (2) times..... Y / N
14. Has your child had any feeding or gastrointestinal problems ..... Y / N
15. Has your child had any problems with urination or urinary tract (kidney) infections ..... Y / N
16. Has your child had any heart problems ..... Y / N
    a. If yes what problems _____
17. Has your child ever had a convulsion or seizure ..... Y / N
18. Has your child had any visual or eye problems ..... Y / N
19. Has your child had any **ALLERGIC REACTIONS TO MEDICATIONS** ..... Y / N
    a. If yes what reaction/medication_____
20. Have any of your children died ..... Y / N
21. Has your child ever been hospitalized or had any surgery ..... Y / N
    a. If yes for what _____
22. Does your child have any other medical or psychological problems that we should know about ..... Y / N
    a. If yes explain _____

FAMILY HISTORY - Please list any family members that have the following problems; include parents, grandparents, aunts, uncles, and cousins. **ANSWER AS IF ANSWERING FOR YOUR CHILD**

AIDS (+HIV Test		Early Deafness		Tuberculosis (TB)	
Depression		Anemia		Alcohol Problems	
Thyroid Problems		Bleeding Problems		Drug Problems	
Diabetes		Migraines		Mental Health Problems	
Cancer/Leukemia		Asthma		Seizures/Epilepsy	
Crib Death (SIDS)		Allergies/Hay Fever		Kidney Prob (& Infection)	
Sinus Problems		Eczema		Lazy Eye	
Inherited Disorders		Cystic Fibrosis		Rheumatoid Arthritis	
Sickle Cell Anemia (or Trait)		Lupus		Other	

Mark an "X" in the box to all that apply

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling 1	Sibling 2
Obesity								
Cardiovascular Disease								
High Blood Pressure								
Stroke								
High Cholesterol								
High Triglyceride								
Type 1 or 2 Diabetes								

Mother's Age _____ Father's Age _____ Please Circle One Married Divorced Other
Who Lives At Home With The Child _____

Parent Signature _____ Date _____/ _____/ _____