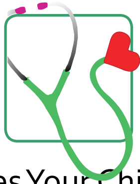
WELCOME TO OAK MILL PEDIATRICS
MEDICAL HISTORY & QUESTIONNAIRE



PATIENT HISTORY [NOT REQUIRED FOR NEWBORNS]

Does Your Child Have or Has She/He Ever Had:

Chickenpox	YES	NO	EXPLAIN ____
Frequent Ear Infections	YES	NO	EXPLAIN ____
Problems With Ears or Hearing	YES	NO	EXPLAIN ____
Problems With Eyes or Vision	YES	NO	EXPLAIN ____
Asthma, Bronchitis, or Pneumonia	YES	NO	EXPLAIN ____
Nasal Allergies	YES	NO	EXPLAIN ____
Any Heart Problem, Heart Murmur	YES	NO	EXPLAIN ____
Anemia or Bleeding Problem	YES	NO	EXPLAIN ____
Blood Transfusion	YES	NO	EXPLAIN ____
Frequent Abdominal Pain	YES	NO	EXPLAIN ____
Constipation Requiring Doctor Visit	YES	NO	EXPLAIN ____
Bladder or Kidney Infection	YES	NO	EXPLAIN ____
Bed Wetting [after 5 years old]	YES	NO	EXPLAIN ____
Any Chronic / Reoccuring Skin Problems	YES	NO	EXPLAIN ____
Frequent Headaches	YES	NO	EXPLAIN ____
Thyroid or Endocrine Problem	YES	NO	EXPLAIN ____
Use of Drugs or Alcohol	YES	NO	EXPLAIN ____
[For Girls] Has She Started Menstrual Period	YES	NO	EXPLAIN ____
[For Girls] Are There Problems With Her Period	YES	NO	EXPLAIN ____
Any Other Significant Problem[s]	____		

FAMILY HISTORY

Have Any Family Members Had The Following:

Deafness	YES	NO	EXPLAIN ____
Nasal Allergies	YES	NO	EXPLAIN ____
Asthma	YES	NO	EXPLAIN ____
Tuberculosis	YES	NO	EXPLAIN ____
Heart Disease [before 50 years old]	YES	NO	EXPLAIN ____
High Blood Pressure [before 50 years old]	YES	NO	EXPLAIN ____
High Cholesterol	YES	NO	EXPLAIN ____
Anemia	YES	NO	EXPLAIN ____
Bleeding Disorder	YES	NO	EXPLAIN ____
Liver Disease	YES	NO	EXPLAIN ____
Kidney Disease	YES	NO	EXPLAIN ____
Diabetes [before 50 years old]	YES	NO	EXPLAIN ____
Bed Wetting [after 10 years old]	YES	NO	EXPLAIN ____
Epilepsy or Convulsions	YES	NO	EXPLAIN ____
Alcohol Abuse	YES	NO	EXPLAIN ____
Drug Abuse	YES	NO	EXPLAIN ____
Mental Illness	YES	NO	EXPLAIN ____
Immune Problems, HIV or AIDS	YES	NO	EXPLAIN ____
Additional Family History	____		