OC Pediatrics Medical Group, Inc.

Date completed: _____

Patient/Child's Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Home Address: _____

City/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Mother's Name: _____ Date of Birth: _____

Home Address(if different from above): _____

City/Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Father's Name: _____ Date of Birth: _____

Home Address(if different from above): _____

City/Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

This child lives with: ☐ Mother only ☐ Father only ☐ Mother/Father ☐ Grandparent/Other _____

Race/Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African-American ☐ Arab ☐ Asian

☐ Other _____

Preferred Language: _____ Do you need a translator? ☐ Yes ☐No

Emergency Contact (not living with you):

Name: _____

Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

How did you hear about us? _____

INSURANCE INFORMATION (Please give your insurance card to the receptionist.)

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PRENATAL HISTORY

While pregnant, did mother have any complications? ☐ yes ☐ no
If Yes, please explain:

Were any prenatal vitamins taken? ☐ yes ☐ no
If Yes, what kind:

BIRTH HISTORY

Where was baby born/hospital? Hepatitis B given?	Gestational Age: _____ weeks Birth Weight _____lbs _____oz Birth Length_____ in/cm
Method of Delivery: ☐ Spontaneous Vaginal ☐ C-section Reason:_____ ☐ Other (ex. Forceps,Vacuum) Reason: _____	Did baby have any complications during hospital stay? ☐Yes☐No If Yes, please explain: _____ _____ Discharged with mother? ☐Yes☐No If No, please explain:_____

FAMILY HISTORY

Are there any cultural or religious practices that might affect your childs medical care? ☐ Yes ☐ No
If yes, please explain: (ex. Blood transfusion, dietary rules):_____
_____

Mother: Age: _____ Height:_____ Current or Past Health Problems: _____	Father: Age: _____ Height: _____ Current or Past Health Problems: _____

Is there anyone in the family who has:

☐ Asthma ☐ Hay Fever ☐ Allergies ☐ Seizures ☐ Headaches

☐ Birth Defects ☐ Genetic Disorder ☐ Large Head ☐ Anemia ☐ Hearing Defect/Loss

☐ Blood Disorder ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke/High Cholesterol

☐ Mental Disorder ☐ Arthritis ☐ Eczema ☐ Skin Disorder ☐ Musculo-Skeletal Disease

☐ Thyroid Disease ☐ High Blood Pressure ☐ Other

If Yes, Please Specify: _____

_____

PAST MEDICAL HISTORY

Has the child had:

☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Meningitis ☐ Strep throat

☐ Contusions ☐ Fractures ☐ Poison Ingestion ☐ Anemia

☐ Heart Defect / Murmur ☐ High Blood Pressure

☐ Chronic Cough ☐ Bronchitis ☐ Pneumonia ☐ Asthma/Wheezing

☐ Jaundice ☐ Bloody Stool ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain

☐ Urinary Tract Infection ☐ Ever wet the bed ☐ Ear infection (if yes, how often?) _____

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☐ Eczema ☐ Acne ☐ Seizures ☐ Fainting ☐ Difficulty with weight

☐ Hospitalization ☐ Operations ☐ Blood Transfusions ☐ Other

If Yes, Please Specify: _____

_____

_____

_____

Any other concerns you would like to discuss: _____

_____

_____

_____ _____

Parent Signature Date

_____

Parent Name (Print)

Doctors Notes:

Patient Name: _____ Date of Birth: _____