

# 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?	Gestational Age: _____ weeks
Hepatitis B given?	Birth Weight _____ lbs _____ oz Birth Length _____ in/cm
Method of Delivery: <input type="checkbox"/> Spontaneous Vaginal <input type="checkbox"/> C-section Reason: _____ <input type="checkbox"/> Other (ex. Forceps, Vacuum) Reason: _____	Did baby have any complications during hospital stay? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please explain: _____ Discharged with mother? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain: _____

## FAMILY HISTORY

Are there any cultural or religious practices that might affect your child's 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:

- |  |  |                                     |  |   |
|--|--|-------------------------------------|--|---|
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Allergies  | <input type="checkbox"/> Seizures      | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Birth Defects   | <input type="checkbox"/> Genetic Disorder    | <input type="checkbox"/> Large Head | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Hearing Defect/Loss      |
| <input type="checkbox"/> Blood Disorder  | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke/High Cholesterol  |
| <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Eczema     | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Musculo-Skeletal Disease |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other      |  |   |

If Yes, Please Specify: \_\_\_\_\_

## PAST MEDICAL HISTORY

Has the child had:

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Measles             | <input type="checkbox"/> Mumps                                    | <input type="checkbox"/> Meningitis      | <input type="checkbox"/> Strep throat   |
| <input type="checkbox"/> Contusions              | <input type="checkbox"/> Fractures           | <input type="checkbox"/> Poison Ingestion                         | <input type="checkbox"/> Anemia          |   |
| <input type="checkbox"/> Heart Defect / Murmur   | <input type="checkbox"/> High Blood Pressure |   |  |   |
| <input type="checkbox"/> Chronic Cough           | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Pneumonia                                | <input type="checkbox"/> Asthma/Wheezing |   |
| <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Bloody Stool        | <input type="checkbox"/> Diarrhea                                 | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Ever wet the bed    | <input type="checkbox"/> Ear infection (if yes, how often?) _____ |  |   |

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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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:

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_