



OLIVE TREE PEDIATRICS

Oklahoma Personalized Pediatric Care

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Medical History Information Sheet

Name _____ DOB: _____

PERINATAL HISTORY

Number of Pregnancies: _____ Number of Living Children: _____

Patient Birth Weight: _____ Gestational Age: _____ Delivery: ___ Vaginal ___ C-Section

Problems During Pregnancy/Labor/Delivery: _____

Allergies: _____

Medications: _____

PATIENT HISTORY:

Past Medical History	No	Yes	Comment on "Yes"
Previous Hospitalization?			
Previous Surgeries Under Anesthesia?			
Previous Injuries?			
On-Going Health Problems?			
Recurrent Illness?			
Abnormal Growth or Development?			
Behavior Problems?			
Need to See Other Doctors/Consultants?			
Are there problems/concerns that we should be aware of and/or discuss? _____			

FAMILY HISTORY

Family Member	Name	DOB	Health Problems
Father			
Mother			
Sibling(s)			



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Any significant history of disease in close relatives? _____ _____			
Any close relatives with sudden death prior to age 50? ___No ___Yes Who? _____ _____			