Oakbrook Pediatrics
202 Benton's Lodge Road
Summerville, SC 29485
(843) 871-2588

Mary Kate Tillman, M.D.
Andrew G. Pittard, M.D.
Kirby J. Smith, M.D.
Barbara A. Miller, M.D.
Mary Lou Korpon, CPNP

Patient History Information

Birth to 12 months

Date _____

Patient Name _____ Date of Birth _____

Mother's name _____ Occupation _____

Father's Name _____ Occupation _____

Childcare arrangements: (Please circle) stay at home Mom, relative, private babysitter, daycare

Do you plan or have you been: (Please circle) breast feeding, bottle feeding

Pregnancy History

Mother's age at birth _____ Baby's due date _____

Hospital _____

Was delivery vaginal or c-section? _____ Gestational age at birth _____

Birth weight _____ Birth length _____

Check any of the following problems during pregnancy:

- infection ☐
- high blood pressure ☐
- hospitalized? ☐
- smoking ☐
- Group B Strep positive ☐
- diabetes ☐
- early labor ☐
- medications ☐
- alcohol/drugs ☐
- other _____

Did the baby have any of the following problems during or after delivery?

- infection ☐
- breathing trouble ☐
- seizures ☐
- failed hearing screen ☐
- jaundice ☐
- feeding ☐
- low blood sugar ☐
- other _____

Has mom had any previous miscarriage or stillbirth? _____

Patient's Past Medical History

Where has your child gone for check-ups until now? _____

Date of last check-up? _____

Serious illness or injury _____

Hospitalizations/operations _____

Current medications _____

Allergic reactions _____

Are your child's immunizations up to date? Any immunization reactions _____

Preferred Pharmacy for prescriptions: _____

Has your child had problems with:

eyes _____ ☐	ears _____ ☐
teeth _____ ☐	wheezing _____ ☐
diarrhea _____ ☐	chronic runny nose _____ ☐
chronic cough _____ ☐	urination _____ ☐
constipation _____ ☐	seizures _____ ☐
skin rashes _____ ☐	anemia _____ ☐

Family History

Who lives in the home? _____

Are parents: single ☐ married ☐ divorced ☐ living together ☐

Are both parents in good health? _____

Sibling's name _____ DOB _____ Healthy? ☐

Sibling's name _____ DOB _____ Healthy? ☐

Sibling's name _____ DOB _____ Healthy? ☐

Are siblings in daycare or preschool? _____

Do any close relatives (mom, dad, siblings, grandparents) have:

asthma/allergies _____ ☐	cystic fibrosis _____ ☐
heart disease _____ ☐	birth defects _____ ☐
high cholesterol _____ ☐	seizures _____ ☐
high blood pressure _____ ☐	sickle cell _____ ☐
irregular heart rate _____ ☐	diabetes _____ ☐
stroke _____ ☐	bleeding disorders _____ ☐
emotional problems _____ ☐	

Safety/Environment

Do you live in a : house ☐ apartment ☐ mobile home ☐ other _____

Have you ever lived in a building built before 1960? _____

Is there a working smoke detector on each floor of your home? _____

Are seatbelts/ carseats always used when riding in a car? _____

Does anyone in the home smoke? _____

Are there problems with the condition of the home? (peeling paint, insects, rodents) _____