



# Oakview Juvenile Residential Center

## MEDICAL HISTORY

**YOUTH NAME:** \_\_\_\_\_

**AGE:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

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### HISTORY:

#### Prenatal and Neonatal Child History:

1. Mother's age at pregnancy: \_\_\_\_\_

2. Number of this pregnancy: \_\_\_\_\_

3. Number of Miscarriages: \_\_\_\_\_

4. Prenatal care:                      Yes              No

5. Smoking during pregnancy:    Yes              No

6. Alcohol during pregnancy:    Yes              No

7. Medication during pregnancy:    Yes              No    If yes, explain: \_\_\_\_\_

\_\_\_\_\_

8. Drug abuse during pregnancy:    Yes              No    If yes, explain: \_\_\_\_\_

\_\_\_\_\_

9. Maternal illness or infection:    Yes              No    If yes, explain: \_\_\_\_\_

\_\_\_\_\_

10. Complications of pregnancy:    Yes              No    If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY- CONTINUED**

11. Complications of labor:            Yes            No    If yes, explain: \_\_\_\_\_

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12. Complications of delivery:        Yes            No    If yes, explain: \_\_\_\_\_

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13. Infant:    birth weight: \_\_\_\_\_    color: \_\_\_\_\_

respiratory distress	Yes	No	
vomiting	Yes	No	
convulsions	Yes	No	
jaundice	Yes	No	
transfusions	Yes	No	
congenital deformity	Yes	No	If yes, explain: _____

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**CHILDHOOD:**

1. Complications of growth and development:            Yes            No

If yes, explain: \_\_\_\_\_

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## MEDICAL HISTORY- CONTINUED

**Family History:**

1. Has anyone in the child's family had the following problems or diseases?

CONDITION	YES OR NO	RELATIONSHIP	SPECIFY
vision problems			
speech problems			
hearing problems			
mental retardation			
attention deficit disorder			
diabetes			
heart disease			
epilepsy			
cancer			
allergies			
alcohol problems			
drug problems			
venereal disease			
asthma			
hypertension			
psychiatric/psychological diagnosis			
tuberculosis			
hypoglycemia			
thyroid disease			
paralysis			
stroke			
bleeding tendencies			