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: _____

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

_____

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: _____

_____

_____

CHILDHOOD:

1. Complications of growth and development: Yes No

If yes, explain: _____

_____

2. Illnesses:

Measles		Yes		No
German Measles	Yes		No	
Chicken Pox	Yes		No	
Mumps	Yes		No	
Scarlet Fever	Yes		No	
Rheumatic Fever	Yes		No	
Meningitis	Yes		No	
Encephalitis	Yes		No	
Pertussis	Yes		No	
Mono	Yes		No	
Gonorrhea	Yes		No	
Pneumonia	Yes		No	
Kidney/Urinary Infections	Yes		No	
Hepatitis	Yes		No	
Syphilis		Yes		No
Herpes	Yes		No	
Vaginal Infections	Yes		No	

3. Allergies:

Skin Sensitivities	Yes	No
Hayfever	Yes	No
Asthma	Yes	No
Foods	Yes	No

If yes, list foods:_____

Medications	Yes	No

If yes, list medications:_____

4. History of bleeding: Yes No If yes, explain: _____

_____

5. Minor or major operations: Yes No If yes, explain : _____

_____

6. Head injuries: Yes No If yes, explain : _____

_____

7. Injuries, hospitalizations, illnesses: Yes No If yes, explain: _____

_____

_____

8. Vision: acuity: Right eye _____ Left eye _____

other problems: Yes No If yes, explain : _____

_____

_____

9. Hearing: problems: Yes No If yes, explain: _____

_____

10. Speech problems: Yes No If yes, explain: _____

_____

11. Other Pediatric Problems: Yes No If yes, explain: _____

_____

12. Current Medications: Yes No If yes, give dose, name,

purpose and prescribing doctor:_____

_____

13. Past Medications: Yes No If yes, give type, dose,

purpose and prescribing doctor:_____

_____

14. Youth's last medical exam: Date Physician

physical	_____	_____
vision	_____	_____
dental	_____	_____

15. Is youth sexually active: Yes No If yes, for how long?

_____

16. Has youth been tested for HIV? Yes No If yes, when: _____

17. Does youth smoke? Yes No

18. Does youth need/wear prescriptive eyeglasses: Yes No

19. Additional Health information:_____

_____

_____

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			