

**Oconee Pediatrics**  
**15579 Wells Highway Seneca, SC 29678**  
**Telephone: 864-882-7800—Fax: 864-882-5908**  
**Frank A. Stewart, DO      Beatriz Gil-Stewart, D.O.**  
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**Jennifer Rice, FNP**

*Patient/Family Health History*

**Patients Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Please help us to care for your child by providing us with a look at the health history of your child and immediate family members. Please circle yes or no to the questions and if the answer is yes, please provide us with a little detail in the space provided. (The provider will ask for more detailed if needed.) On the reverse side, please answer the same questions regarding the immediate family. Thank you for choosing Oconee Pediatrics to care for your child!**

*Your Child's Health History*

- |   |            |           |       |
|---|------------|-----------|-------|
| <b>1. Heart or Circulation</b>            | <b>Yes</b> | <b>No</b> | _____ |
| <b>2. Lung or Respiratory</b>             | <b>Yes</b> | <b>No</b> | _____ |
| <b>3. Liver, Gallbladder, Spleen</b>      | <b>Yes</b> | <b>No</b> | _____ |
| <b>4. Kidney or Urinary Tract</b>         | <b>Yes</b> | <b>No</b> | _____ |
| <b>5. Genitalia</b>                       | <b>Yes</b> | <b>No</b> | _____ |
| <b>6. Brain or Nerves</b>                 | <b>Yes</b> | <b>No</b> | _____ |
| <b>7. Muscles</b>                         | <b>Yes</b> | <b>No</b> | _____ |
| <b>8. Bones or Joints</b>                 | <b>Yes</b> | <b>No</b> | _____ |
| <b>9. Skin or Hair</b>                    | <b>Yes</b> | <b>No</b> | _____ |
| <b>10. Blood Disorders</b>                | <b>Yes</b> | <b>No</b> | _____ |
| <b>11. Nutrition or Growth</b>            | <b>Yes</b> | <b>No</b> | _____ |
| <b>12. Behavior or Development</b>        | <b>Yes</b> | <b>No</b> | _____ |
| <b>13. Genetic or Inherited Disorders</b> | <b>Yes</b> | <b>No</b> | _____ |
| <b>14. Problems with Pregnancy/Birth</b>  | <b>Yes</b> | <b>No</b> | _____ |
| <b>15. Surgeries</b>                      | <b>Yes</b> | <b>No</b> | _____ |
| <b>16. Vision or Hearing</b>              | <b>Yes</b> | <b>No</b> | _____ |
| <b>17. Dental</b>                         | <b>Yes</b> | <b>No</b> | _____ |
| <b>18. Medicine Allergies</b>             | <b>Yes</b> | <b>No</b> | _____ |
| <b>19. Recurrent Infections</b>           | <b>Yes</b> | <b>No</b> | _____ |
| <b>    or Difficulty Resolving</b>        |            |           |       |
| <b>20. Environmental Allergies</b>        | <b>Yes</b> | <b>No</b> | _____ |

**OVER PLEASE**

*Your Child's Immediate Family Health History*  
*(Brother/Sister, Parents, Grandparents, Aunts/Uncles)*

- |   |            |           |       |
|---|------------|-----------|-------|
| <b>21. Heart or Circulation</b>           | <b>Yes</b> | <b>No</b> | _____ |
| <b>22. Lung or Respiratory</b>            | <b>Yes</b> | <b>No</b> | _____ |
| <b>23. Liver, Gallbladder, Spleen</b>     | <b>Yes</b> | <b>No</b> | _____ |
| <b>24. Kidney or Urinary Tract</b>        | <b>Yes</b> | <b>No</b> | _____ |
| <b>25. Genitalia</b>                      | <b>Yes</b> | <b>No</b> | _____ |
| <b>26. Brain or Nerves</b>                | <b>Yes</b> | <b>No</b> | _____ |
| <b>27. Muscles</b>                        | <b>Yes</b> | <b>No</b> | _____ |
| <b>28. Bones or Joints</b>                | <b>Yes</b> | <b>No</b> | _____ |
| <b>29. Skin or Hair</b>                   | <b>Yes</b> | <b>No</b> | _____ |
| <b>30. Blood Disorders</b>                | <b>Yes</b> | <b>No</b> | _____ |
| <b>31. Nutrition or Growth</b>            | <b>Yes</b> | <b>No</b> | _____ |
| <b>32. Behavior or Development</b>        | <b>Yes</b> | <b>No</b> | _____ |
| <b>33. Genetic or Inherited Disorders</b> | <b>Yes</b> | <b>No</b> | _____ |
| <b>34. Problems with Pregnancy/Birth</b>  | <b>Yes</b> | <b>No</b> | _____ |
| <b>35. Surgeries</b>                      | <b>Yes</b> | <b>No</b> | _____ |
| <b>36. Vision or Hearing</b>              | <b>Yes</b> | <b>No</b> | _____ |
| <b>37. Dental</b>                         | <b>Yes</b> | <b>No</b> | _____ |
| <b>38. Medicine Allergies</b>             | <b>Yes</b> | <b>No</b> | _____ |
| <b>39. Recurrent Infections</b>           | <b>Yes</b> | <b>No</b> | _____ |
| <b>    or Difficulty Resolving</b>        |            |           |       |
| <b>40. Environmental Allergies</b>        | <b>Yes</b> | <b>No</b> | _____ |

**41.**  
**Other** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_