PROVIDENCE
Medical Group
Mercantile

NEW PATIENT HEALTH HISTORY FORM - PEDIATRIC

Name: _____ Date of Birth: _____ Age: _____

Mother's Name: _____ Occupation: _____

Father's Name: _____ Occupation: _____

Child lives with (circle): Both Parents together Mother Father other: _____

Does anyone living in the home smoke? Yes No

Siblings: 1. _____ Age: _____ 4. _____ Age: _____

2. _____ Age: _____ 5. _____ Age: _____

3. _____ Age: _____ 6. _____ Age: _____

What would you like to discuss at **today's visit**? _____

Birth History. Please give us more information about your child's birth: Adopted? Y / N If yes, what age? _____

Prenatal Care started at about _____ weeks Delivery was: Vaginal ? C-section? Did mom have diabetes? Y / N

Born at how many weeks? _____ Birth weight _____ Any complications such as jaundice, infection, feeding problems? _____

Past Medical History. Please circle any health issues your child has experienced:

Allergies Asthma Ear Infections Hearing problems Vision problems Concussion Eczema Thyroid
Diabetes Heart Problems Urinary Problems Kidney Problems Depression Anxiety ADD/ADHD
Developmental/Growth problems Chicken Pox Unusual infections Joint problems Broken Bones Scoliosis

For girls only: Started period yet? If so, what age? _____ Any concerns? _____

Other:_____

Surgical History. Has your child had any surgeries? (circle) Yes No

Surgery: _____ When? _____ Where? _____

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Any other hospitalizations overnight? If yes, Where, when and why?_____

Allergies. Please list any foods or medication allergies: _____

Any special dietary restrictions? If yes, explain _____

Family History. Please list any chronic or serious health issues for the following relatives (including mental health):

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Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

School/Child Care/Interests.

Does your child go to school? Yes No If yes, where? _____ grade_____

Any childcare? If yes, how many hours per week? _____

Does your child participate in any activities outside the home? _____

How much screen time per day (computer, TV, phone, video games): _____ hours

How much physical activity per day? _____ Hours

Do you have concerns about your child's: behavior? Y / N weight? Y / N nutrition? Y / N sleep? Y / N

Current Medications. Please list your any medications or supplements your child is taking or has on hand:

Medication:	Dose:	Frequency of Use:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dental Care:

Is your home water supply fluoridated? Y / N / Don't know Fluoride Supplement? Y / N

Has your child seen the dentist? Y / N Last visit: _____ Any history of cavities? Y/ N

Immunization History.

Is your child up-to-date on recommended immunizations? (circle) Yes No Unknown Not vaccinated by choice

Any specific updates needed today? _____

Has your child had any immunizations outside the state of Oregon? If yes, where? _____

Past Medical Providers. We can request medical records from your child's previous clinicians or any specialists recently seen, to better coordinate care. Please list them here:

Name _____ City/State _____