Providence Medical Group-
Scholls Pediatrics
12442 SW Scholls Ferry Road
Tigard, Oregon 97223
Phone: 503 216-9140

Welcome to PMG Scholls Pediatrics

Name: ______________________________________ Date of Birth: _________________________ Today's Date:_________________________
Preferred Name (if different): ________________________

Welcome to PMG Scholls Pediatrics! You're here because your family's health is important to you and it's important to us as well. Thank you for filling out this new patient form so together we can provide the highest quality healthcare and best experience for you and your family.

What is the **most important** issue for us to address at today's visit?

____

____

For a future visit or if we have time today, what other concerns do you have?

1) ____
2) ____
3) ____

Do you need any medications **refilled, referrals, forms completed, or a letter for school** today? ☐ Yes ☐ No

BIRTH HISTORY – (if applicable)

Birth Length: _______________________________

Birth Weight: ______________________________

Birth Head Circumference: ____________________

Discharge Weight: ___________________________

Gestational Age: ___________________________

Delivery Method: ___________________________

Duration of Labor: __________________________

Feeding Method: ___________________________

MEDICAL HISTORY – if applicable

ADD/ADHD ☐ Yes ☐ No	Diabetes mellitus ☐ Yes ☐ No	Otitis Media ☐ Yes ☐ No
Anaphylaxis ☐ Yes ☐ No	Eczema ☐ Yes ☐ No	Overdose ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No	Environmental Allergies ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Failure to thrive ☐ Yes ☐ No	Prematurity ☐ Yes ☐ No
Bleeding disorder ☐ Yes ☐ No	GERD ☐ Yes ☐ No	Problem with anesthesia ☐ Yes ☐ No
Blood transfusion ☐ Yes ☐ No	Hearing Loss ☐ Yes ☐ No	Recurrent tonsillitis ☐ Yes ☐ No
Chronic diarrhea ☐ Yes ☐ No	Heart murmur ☐ Yes ☐ No	Scoliosis ☐ Yes ☐ No
Clotting Disorder ☐ Yes ☐ No	Hydrocephalus ☐ Yes ☐ No	Seizures ☐ Yes ☐ No
Congenital heart disease ☐ Yes ☐ No	Inflammatory bowel disease ☐ Yes ☐ No	Strep Throat (recurrent) ☐ Yes ☐ No
Constipation ☐ Yes ☐ No	Jaundice ☐ Yes ☐ No	UTI ☐ Yes ☐ No
Cerebral Pasley ☐ Yes ☐ No	Meningitis ☐ Yes ☐ No	Varicella ☐ Yes ☐ No
Depression ☐ Yes ☐ No	Metabolic Disorder ☐ Yes ☐ No	Vision Problems ☐ Yes ☐ No
Developmental delay ☐ Yes ☐ No	Obesity ☐ Yes ☐ No	
Other?		

SURGICAL HISTORY – if applicable

Adenoidectomy ☐ Yes ☐ No	Heart Surgery ☐ Yes ☐ No	TE Fistula Repair ☐ Yes ☐ No
Appendectomy ☐ Yes ☐ No	Inguinal Hernia ☐ Yes ☐ No	Testicle Surgery ☐ Yes ☐ No
Cholecstectomy ☐ Yes ☐ No	Knee Surgery ☐ Yes ☐ No	Tonsillectomy ☐ Yes ☐ No
Ear Tubes ☐ Yes ☐ No	Lynph node Biopsy ☐ Yes ☐ No	Trachostomy ☐ Yes ☐ No
Fracture Surgery ☐ Yes ☐ No	Spine Surgery ☐ Yes ☐ No	Umbillical hernia ☐ Yes ☐ No
Fundoplication ☐ Yes ☐ No	Tonsillectomy & Adenoidectomy ☐ Yes ☐ No	VP Shunt ☐ Yes ☐ No
G-Tube ☐ Yes ☐ No		
Other?		

FAMILY HISTORY

Relationship	Name	Alive	No Known Problem	Allergies	Anemia	Arthritis	Asthma	Attention Deficit Disorder	Autism	Auto Immune Disorder	Birth Defects	Bleeding Problems	Brain Aneurysm	Cancer	Clotting Disorder	Cystic fibrosis	Developmental Disorder	Diabetes	Early Death	Eczema	Headache	Hearing Loss
Mother																						
Father																						
Sister																						
Brother																						
Maternal Aunt																						
Maternal Uncle																						
Paternal Aunt																						
Paternal Uncle																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
Other																						

FAMILY HISTORY (Cont)

Relationship	Name	Alive	Heart arrhythmias	Heart Disease	Premature CHD	High Blood Pressure	High Cholesterol	Inflammatory Bowel Disease	Kidney Disease	Learning Disability	Mental Illness	Migraines	Muscular Dystrophy	Anesth Problems	Seizures	Stroke	Substance Abuse	Thyriod Disease	Tuberculosis	Vision loss	Other
Mother																					
Father																					
Sister																					
Brother																					
Maternal Aunt																					
Maternal Uncle																					
Paternal Aunt																					
Paternal Uncle																					
Maternal Grandmother																					
Maternal Grandfather																					
Paternal Grandmother																					
Paternal Grandfather																					
Other																					

Any other details we should know about your family? ____
____

SOCIAL HISTORY

Who does your child live with? ____

Does your child have siblings? ☐ Yes ☐ No

Is your child in Foster Care? ☐ Yes ☐ No

What are the occupations of the patient's parents or primary caregivers? ____

Does the patient have another caregiver? ____

Does your child attend Physical Therapy? ☐ Yes ☐ No

Does your child attend Occupational Therapy? ☐ Yes ☐ No

Does your child attend Behavioral Health Therapy? ☐ Yes ☐ No

Does your child attend Speech Therapy? ☐ Yes ☐ No

Does your child attend the resource room at School? ☐ Yes ☐ No

Is your child exposed to pets at any home or while with a caregiver? ☐ Yes ☐ No

What type of Pet? ____

Is your child exposed to anyone that smokes or vapes? ☐ Yes ☐ No

Primary language? ____

What school does your child attend? ____

What grade? ____

Does your child have an IEP or other special accommodations for school? ____

____

Thank you for completing your new patient form!