PROVIDENCE
Medical Group
Wilsonville

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? ___________________________________

Surgery: _________________________________ When? _________ Where? ___________________________________

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):

PROVIDENCE Medical Group Wilsonville

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 __________________________