Oregon Medical Group
Pediatric Medical History Form

(Please fill out as completely as possible at, or prior, to child's first visit with a provider.)

Place label here.

Filled out by: _____

Most recent physical or wellness visit: _____

Name and location of last provider/doctor: _____

Other doctors (specialists involved in the child's care): _____

PREGNANCY AND BIRTH

Please check if birth information is not known. ☐

Where was the child born? _____

Please indicate any problems during pregnancy: _____

During the pregnancy was there exposure to: ☐Cigarettes ☐Marijuana ☐Alcohol ☐Other

Delivery by: ☐ Cesarean Section ☐ Vaginal

Was the baby born on time? ☐Yes ☐ No If not, how many weeks early/late? _____

Did baby leave the hospital with mother? ☐ Yes ☐ No

SOCIAL HISTORY

Is this child yours by: ☐ Adoption ☐ Birth ☐ Stepchild ☐ Foster ☐ Other

Are the child's parents: ☐ Married ☐ Divorced ☐ Unmarried ☐ Separated ☐ Remarried

If separated, when? _____

Mother's age: _____ Occupation: _____ Father's age: _____ Occupation: _____

Who lives at home with the child? *(If the child spends time in two households please indicate.)*

Name **Age** **Relationship**

_____

_____

_____

_____

_____

Please list names/ages of any siblings NOT living in the household: _____

_____

Does anyone in the child's household smoke? ☐Yes ☐No

FAMILY HISTORY

Please indicate if **THE CHILD'S grandparent, parent, sibling, aunt or uncle** has:

Diabetes		Anxiety	
Cystic Fibrosis		Learning Disability	
High Cholesterol		Thyroid Disease	
High Blood Pressure		Bleeding/Clotting Disorder	
Heart Attack under age 60		Deafness	
Stroke under age 60		Alcohol Dependency	
Seizure/Convulsion		Drug Dependency	
ADD/ADHD		Cancer	
Anemia/"Low Blood"		Melanoma	
Depression		Asthma	

PLEASE COMPLETE BOTH PAGES IF THE CHILD IS NOT A NEWBORN

Physician Sign/Date: _____

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MEDICATIONS

Medications and/or Vitamins and doses: _____

_____

Herbs/Home Remedies: _____

_____

Allergies/Reactions to Medications: _____

_____

PAST MEDICAL HISTORY

Has the child been hospitalized? ☐ Yes ☐ No Any operations or surgical procedures? ☐ Yes ☐ No

If yes, please list procedure and approximate date: _____

Please check any medical problems the child has had below:

☐ Diabetes	☐ Developmental Delay	☐ Anxiety	☐ Autism
☐ Cystic Fibrosis	☐ Vomiting/Heartburn	☐ Learning Disability	☐ Sleep Problems
☐ High Cholesterol	☐ Ongoing Abdominal Pain	☐ Thyroid Disorder	☐ ADD/ADHD
☐ High Blood Pressure	☐ Migraine/Chronic Headache	☐ Bleeding/Clotting Disorder	☐ Ongoing Constipation
☐ Heart Attack	☐ Overweight	☐ Deafness/Hearing Problem	☐ Depression
☐ Stroke	☐ Underweight	☐ Allergies	☐ Ongoing Diarrhea
☐ Seizure/Convulsion	☐ Scoliosis	☐ Asthma/Uses Inhalers	

IMMUNIZATIONS

Has the child ever had a severe reaction to a vaccine? ☐ Yes ☐ No

Please provide a copy of the child's immunization card to your provider's assistant.

NUTRITION AND FEEDING *(if one year or older)*

Was the child breastfed? ☐ Yes ☐ No If yes, how long? _____

Has the child has any unusual feeding problems? ☐ Yes ☐ No If yes, what kind? _____

Milk intake now: ☐ Cow's Milk ☐ Nonfat ☐ 1% ☐ 2% ☐ Whole ☐ Soy Milk ☐ Almond Milk

How many ounces per day (8oz in 1 cup)? _____

DENTAL HISTORY

Has the child been seen by a dentist? ☐ Yes ☐ No Date of last visit: _____

Any concerns with the child's teeth? _____

DEVELOPMENTAL/EDUCATION

Has the child been referred for, or received, special developmental or education services such as speech therapy, physical therapy, or special help in school? ☐ Yes ☐ No

Have you had any concerns about the child's special development? ☐ Yes ☐ No

Have you had concerns about the child's emotional or social development? ☐ Yes ☐ No

If yes to either, please describe: _____

Does the child attend school? ☐ Yes ☐ No If yes, name of school and current grade: _____

If not in school, or during non-school hours, who cares for the child?

☐ Exclusively at home with parents ☐ In-home daycare ☐ Day care program ☐ With family/friends

PLEASE COMPLETE BOTH SIDES IF THE CHILD IS <u>NOT</u> A NEWBORN

Physician Sign/Date: _____