Today's Date: _____

CLACKAMAS Health Centers

Name: _____
DOB: ___/___/___
MRN: _____ (or place label here)

Pediatric Medical History
(Ages 0-11)

Please complete this form about your child. You can skip the questions you don't know the answer to. This information will help us give you better care.

Do you need help filling out medical forms? ❑ Yes ❑ No

How do you learn best?
❑ Reading information ❑ Hearing information ❑ Pictures ❑ Learn by doing (hands on)

How do you want to get information?
❑ In writing ❑ Tell me ❑ Show me

MEDICAL HISTORY

1. Has your child had an allergic reaction (bad effect) from any of the following?
❑ No known allergies ❑ Medicines/Drugs (please describe) _____
❑ Latex (rubber gloves) ❑ Eggs ❑ Peanuts ❑ Bee stings ❑ Shellfish
❑ Other (please describe) _____

2. Is your child taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements) daily? ..... YES ❑ NO ❑
If yes – please list:

3. Has your child had any of the following health problems or symptoms?

❑ Allergies (seasonal, hay fever, etc)
❑ Asthma
❑ Autoimmune disorder (lupus/juvenile arthritis/celiac disease)
❑ Blood disorders (sickle cell/clotting problems)
❑ Cancer: Type_____
❑ Diabetes:
(circle one) pre-diabetes, type 1, or type 2
❑ Heart problems (including murmur or high blood pressure)
❑ High cholesterol
❑ Broken bones: where? _____
❑ Cavities or tooth pain/injuries
❑ Missing or damaged organs (eye, kidney, testicle)
❑ Many headaches/migraines
❑ Head injury, concussion or seizures
❑ Problems since birth (birth defect, down syndrome, autism, genetic disorder)
Type: _____
❑ Developmental delay
❑ Learning disability or special education needs (IEP or 504 plan)
❑ Mental health condition (ADHD, anxiety, depression, etc.)
❑ Other_____

4. Has your child had any major injuries or been in the hospital overnight? ..... YES ❑ NO ❑
If yes – what surgeries/injuries or why were they in the hospital?

FLIP OVER FOR ADDITIONAL QUESTIONS

BIRTH HISTORY

5. What city/country was your child born in? _____

6. Was your child born more than one month early? ..... YES ❑ NO ❑

7. Were there problems with the pregnancy or birth?..... YES ❑ NO ❑
If yes- what?

8. Did the mother smoke, use drugs, or drink alcohol during the pregnancy, *including before she knew she was pregnant?* ..... YES ❑ NO ❑
If yes- what?

FAMILY MEDICAL HISTORY

Medical problems can run in families. Please check the boxes below to tell us about any health problems your child's family members have had.

Mother (biological): Living? ❑ Yes ❑ No ❑ I don't know
❑ Has no medical problems
❑ Diabetes (sugar) ❑ Alcohol/Drug abuse ❑ Heart problems
❑ Stroke/blood clots ❑ High blood pressure ❑ Mental health condition (depression, anxiety, ADHD, etc.)
❑ Cancer: what type? _____
❑ Other _____

Father (biological): Living? ❑ Yes ❑ No ❑ I don't know
❑ Has no medical problems
❑ Diabetes (sugar) ❑ Alcohol/Drug abuse ❑ Heart problems
❑ Stroke/blood clots ❑ High blood pressure ❑ Mental health condition (depression, anxiety, ADHD, etc.)
❑ Cancer: what type? _____
❑ Other _____

Sister/Brothers: How many? _____ Living? ❑ Yes ❑ No ❑ I don't know
❑ Has no medical problems
❑ Diabetes (sugar) ❑ Alcohol/Drug abuse ❑ Heart problems
❑ Stroke/blood clots ❑ High blood pressure ❑ Mental health condition (depression, anxiety, ADHD, etc.)
❑ Cancer: what type? _____
❑ Other _____

Signature X _____ (Parent/Guardian)

for office use: Provider
Reviewed by: _____ Date: _____