GRANTS PASS MEDICAL
1701 NW Hawthorne Avenue, Suite 201
Grants Pass, OR 97526
(541) 471-3455

CAVE JUNCTION MEDICAL
25647 Redwood Highway
Cave Junction, OR 97523
(541) 592-4111

PEDIATRIC HEALTH HISTORY

This form must be completed in full, including all dates.

Patient Name: *(Please print)* ____ Date of Birth: ______________

Name of Person Completing Form: ________________________________ Relationship to Child: ______________

Primary Care Provider: ____ Today's Date: ___________________

MEDICAL HISTORY

LIST MEDICAL CONDITION(S)	CURRENT? Y/N	DATE DIAGNOSED	PROVIDER SEEN	OFFICE USE

ALLERGIES

☐ *No Allergies*

NAME	REACTION	NAME	REACTION
1.		3.	
2.		4.	

MEDICATION(S) *(Including over the counter, herbal supplements and vitamins)*

NAME OF MEDICATION	CURRENT? Y/N	PRESCRIBED BY

SISKIYOU COMMUNITY HEALTH CENTER
PEDIATRIC HEALTH HISTORY (Page 2 of 3)

This form must be completed in full, including all dates.

Patient Name: *(Please print)* ____ Date of Birth: _______________

SURGICAL HISTORY *(Please include year of surgery)*

SURGICAL PROCEDURE	DATE	PHYSICIAN

IMMUNIZATION HISTORY *(OR attach copy of child's immunization records)*

VACCINE	LOCATION	DATE
DTaP (Diphtheria, Pertussis, Tetanus)		
Flu (Influenza)		
HepA (Hepatitis A)		
HepB (Hepatitis B)		
Hib (Haemophilus Influenza)		
HPV (Human Papillomavirus)		
IPV (Polio)		
Meningococcal (Meningitis)		
MMR (Measles, Mumps, Rubella)		
PCV (Pneumococcal)		
RV (Rotavirus)		
TdaP (Diphtheria, Pertussis, Tetanus)		
Varicella (Chickenpox)		
Other: _________________________		

FAMILY HEALTH HISTORY *Have any of your relatives had any of the following?*

DIAGNOSIS	CHECK ALL THAT APPLY	RELATIONSHIP	LIVING?
ADD / ADHD			
Alcoholism			
Allergies			
Alzheimer's Disease			
Arthritis			
Asthma			
Bipolar Disorder			
Birth Defects Type: ________________			
Blood Disease			
Cancer Type: ________________			
CVA (Stroke)			
Depression			
Developmental Delay			
Diabetes			
Eczema			

DIAGNOSIS	CHECK ALL THAT APPLY	RELATIONSHIP	LIVING?
Heart Disease			
High Cholesterol			
High Blood Pressure			
Learning Disability			
Lung Disease			
Mental Illness			
Migraines			
Obesity			
Osteoporosis			
Renal Disease			
Seizure Disorder			
Thyroid Disease			
Other:			
Other:			
Other:			

SISKIYOU COMMUNITY HEALTH CENTER
PEDIATRIC HEALTH HISTORY (Page 3 of 3)
This form must be completed in full, including all dates.

Patient Name: *(Please print)* ____ Date of Birth: _______________

PREGNANCY / BIRTH HISTORY

Type of Delivery: ☐ Vaginal ☐ C-Section Reason for C-Section: ____________________________

Gestational Age (Weeks): ______________________________ Birth Weight: ___________________________________

Pregnancy / Delivery Complications? ☐ Yes ☐ No If yes, what complications? ________________________

Did your child pass their newborn hearing test? ☐ Yes ☐ No

Breastfed? ☐ Yes ☐ No If yes, for how long? _____________________________

Bottle-fed? ☐ Yes ☐ No If yes, what formula type? ________________________

Has your child had jaundice? ☐ Yes ☐ No If yes, what kind of treatment did they receive? ____________________

Is your child enrolled in WIC? ☐ Yes ☐ No

SOCIAL HISTORY

Primary Residence: (*With whom does your child live most of the time?*) ____

Secondary Residence: (*With whom does your child live part-time, if applicable?*) ____________________________________

Parents' Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Language: ____________________________ Language(s) Spoken at Home: _______________________________

EDUCATION

School Name: ____ Grade Level: _____________________________

Any Learning Disabilities? ☐ Yes ☐ No If yes, what disabilities? ___________________________________

Any Special Needs in School? ☐ Yes ☐ No If yes, what special needs? _________________________________

ACTIVITIES

Exercise / Sports? ☐ Yes ☐ No If yes, what type? _________________________ Hours per week? _____

TV / Computer Games? ☐ Yes ☐ No If yes, how many hours per day? ________________________________

Does child have a TV in their bedroom? ☐ Yes ☐ No

Does child have a computer in their bedroom? ☐ Yes ☐ No

HOME ENVIRONMENT / SAFETY

Dental Provider: _____________________________________ Last Exam: _______________________________________

☐ SCHC Provider ☐ Other ☐ None

Home Heating Type: __________________________________ ☐ None (*No heat source*)

Are there any smokers in the child's home? ☐ None ☐ Inside ☐ Outside Only

Are there smoke detectors in the home? ☐ Yes ☐ No

Does the child use a bike / skating helmet? ☐ Yes ☐ No

What type of car restraint is used? ☐ Rear-facing Car Seat ☐ Front-facing Car Seat ☐ Booster
☐ Seatbelt ☐ None