



CLACKAMAS PEDIATRIC CLINIC & OREGON PEDIATRICS
c/o 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015

Today's Date ___/___/___

Child's Name _____ Male/Female Date of Birth ___/___/___ Age ___

Mother _____ Age ___ General health: Good Poor Fair

Father _____ Age ___ General health: Good Poor Fair

Siblings (Names, Ages & general health) _____

Parent/Guardian - please answer the following questions.

At this time, what are your primary concerns regarding this child's health? _____

Does child have any allergies to medications? NO / YES (if yes, please list) _____

Date of last wellness exam: _____ Current medications (if any): _____

Immunization DTP/DTaP _____ MMR _____

OPV/IPV _____ Prevnar _____

Dates: Hib _____ Varivax _____

HEP B _____ HEP A _____

HPV _____ Meningococcal _____ Rotavirus _____

OTHER _____

Last Test Dates: PKU _____ Hemoglobin _____ TB/PPD _____ Urine _____

Difficulties with pregnancy or delivery (if any): _____

Mother received appropriate prenatal care? Yes / No _____

FAMILY HISTORY

Does child or any blood relative, currently have or previously has had, any of the following (if so, who?):

Cancer _____ Heart problems _____ Asthma _____ Anemia _____

Leukemia _____ Diabetes _____ Epilepsy _____ Pneumonia _____

Ulcers _____ Headaches _____ High Blood Pressure _____ Stroke _____

Jaundice _____ Rheumatic Fever _____ Kidney Disease _____ Other _____

Other significant illness (please list) _____

Family history of psychiatric conditions (if any) _____

Any previous surgery and approximate date(s) _____

Any previous fracture and approximate date(s) _____

Other serious injuries (if any) _____

HABITS

Wears seat belt &/or uses approved car seat..... Always Usually Sometimes Never
Uses safety equipment when bicycling, skating, rollerblading,..... Always Usually Sometimes Never
Gets an acceptable amount of exercise daily..... Always Usually Sometimes Never
Gets an acceptable amount of sleep daily..... Always Usually Sometimes Never
Daily brushing and flossing of teeth..... Always Usually Sometimes Never
Uses coffee..... Daily Occasionally Never Amount _____
Uses tobacco..... Daily Occasionally Never Amount _____
Uses alcohol..... Daily Occasionally Never Amount _____
Uses drugs (other than for medical reasons)..... Daily Occasionally Never Amount _____