orchidhealth
Exceptional, local healthcare

New Patient Health History - Pediatric 6-17 years

Name: ______________________ **Date of Birth:** ________________ **Today's Date:** ________________

Current Medical Concerns (what you would like to talk about today):

____

____

Please list any allergies you have to medications:

____

____

Please list any medications you currently take, including over the counter medications, supplements, or vitamins:

____

____

Have you received any immunizations outside of Oregon? If so, where? ______________________________________

Have you been to the hospital multiple times for the same issue in the last 2 years?

❒Yes ❒No If yes, please explain below:

____

____

Please mark any surgeries that you have had:

❒ Heart ❒ Ear Tubes ❒ Tonsils/Adenoids ❒ Appendix ❒ Eye Surgery ❒ Hernia Repair, type: __________

❒ Other: _________________

PERSONAL HEALTH HISTORY

Please list any current or historical medical problems/concerns that your child has had:

____

____

____

Please list health conditions that your child's family members have:

____

____

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Do you or have you ever smoked tobacco? ❒ Yes ❒ No
How Many Years did you smoke tobacco? ______
Do you use or have you used other forms of tobacco, like chewing tobacco? ❒ Yes ❒ No
Do you use e-cigarettes (vape)? ❒ Yes ❒ No

Education and Activity

Grade in School: _________________ Name of School: ____
Do you have any concerns about your child's performance in school? ❒Yes ❒No
What does your child enjoy doing? ____
Any concerns about bullying? ❒Yes ❒No
Screen Time (TV/Computer/Phone/Tablet) daily (on average)? ❒ None ❒ Less than one hour ❒ 1-2 hours ❒ 3 hours or more
How much time is spent outside daily (on average)? ❒ None ❒ A few minutes ❒ One hour ❒ More than one hour

Do you have any concerns about your child's relationship to food or their body? ❒Yes ❒No
If yes, please specify: ____

Is there anything else we have missed that you feel we should know?
____
____