orchidhealth
Exceptional, local healthcare

New Patient Health History - Pediatric 0-5 years

Name: ________________________ **Date of Birth:** __________________ **Today's Date:** _________________

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

____

Do you have any concerns about your child's hearing or vision? ____

Please list any allergies your child has to medications: ____

Please list any medication your child currently takes, including over the counter medications, supplements, or vitamins:

____

____

Has your child received any immunizations outside of Oregon? If so, where? _________________________________

Has your child ever been hospitalized? ❒ Yes ❒ No If yes, please explain:

____

____

Please list any surgeries that your child has had: ____

Prenatal and Birth History

Did this child's mother receive prenatal care? ❒ Yes ❒ No ❒ Don't know

Gestational age at birth: _____ weeks Type of delivery: ❒ Vaginal ❒ C-section

Describe any complications that occurred during pregnancy or delivery: ______________________________________

____

FAMILY HEALTH HISTORY
Please list health conditions that your child's family members have (if known):

____

____

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

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