Patient History

Patient Name _____ **Date of Birth** _____ **Gender** _____

MOTHER: Number of pregnancies _____ **Number of live births** _____

NEONATAL: ☐ premature ☐ full-term ☐ vaginal delivery ☐ c-section **Birth Weight** _____

Birth complications _____

Race/Ethnicity _____ **Language spoken at home** _____

Primarily lives with: ☐ both parents ☐ mother ☐ father ☐ other _____

Place of residence: ☐ house ☐ apartment ☐ other _____

PATIENT HEALTH INFORMATION

	Yes	No	List
Allergies to medications			
Medications (name, dose, and include over-the-counter products such as vitamins)			
Hospital admissions (date and reason for admission)			
Surgeries (date and procedure)			
Major illness history (pneumonia, wheezing, etc)			
Major injury history (fractures, concussions, etc)			

THIS INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signed by _____ **Date** _____

Print Name _____ **Relationship** _____

SPC ONLY

PCP _____

R _____ **D** _____

Salem Pediatric Clinic

2478 13th Street SE
Salem, Oregon 97302
503-362-2481 · Phone
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SalemPediatricClinic.com

Patient History

FAMILY HEALTH INFORMATION

	Patient	Mother	Father	Siblings	Gparents	Aunts	Uncles
ADD/ADHD							
Anesthetic Reaction							
Asthma							
Autism							
Bleeding/Clotting Disorder							
Cancer							
Depression/Anxiety							
Diabetes							
Early Unexplained Death							
Elevated Cholesterol							
Heart Attack (age)							
Heart Disease							
High Blood Pressure							
Mental Health – Other (Bipolar, Schizophrenia)							
Migraines							
Scoliosis							
Seasonal Allergies							
Seizure Disorder							
Thyroid Disease							

Other conditions or information

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