

## Patient Information



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

MR#: \_\_\_\_\_ Date of Service: \_\_\_\_/\_\_\_\_/\_\_\_\_

- American Indian or Alaska Native       Asian       Black or African American       Hispanic  
 Native Hawaiian or other Pacific Islander       White (non-Hispanic)       Other

**Welcome to The Children's Clinic of Klamath!** Please take the time to fill out this form as accurately as possible so we can most appropriately address your child's health needs. Thank you!

### BIRTH HISTORY—Pregnancy

Did mother...

...smoke?  Yes  No ...drink alcohol?  Yes  No ...

use drugs/medications?  Yes  No

If yes, what kind(s)?

\_\_\_\_\_ ...experience illness/

complications?  Yes  No

If yes, what kind(s)? \_\_\_\_\_

### BIRTH HISTORY—Delivery/Newborn Period Delivery

Type:  Vaginal  C-section

Gestational Age: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Date

hepatitis B given: \_\_\_\_/\_\_\_\_/\_\_\_\_

Problems in newborn period: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PATIENT MEDICAL HISTORY

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> ADD/ADHD          | <input type="checkbox"/> Hearing loss               | <input type="checkbox"/> Scoliosis                |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Heart murmur               | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Immune deficiency          | <input type="checkbox"/> Sickle cell              |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Strep throat (recurrent) |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Jaundice                   | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Cancer/Oncology   | <input type="checkbox"/> Meningitis                 | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Otitis media               | <input type="checkbox"/> UTI                      |
| <input type="checkbox"/> Eating disorder   | <input type="checkbox"/> Pneumonia                  | <input type="checkbox"/> Varicella (chickenpox)   |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> Prematurity                | <input type="checkbox"/> Vision problems          |
| <input type="checkbox"/> Headaches         |   |   |
| <input type="checkbox"/> Other: _____      |   |   |

### PATIENT SURGICAL HISTORY

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Adenoidectomy    | <input type="checkbox"/> C-section        | <input type="checkbox"/> Lymph node biopsy            |
| <input type="checkbox"/> Appendectomy     | <input type="checkbox"/> Fracture surgery | <input type="checkbox"/> Tonsillectomy                |
| <input type="checkbox"/> Circumcision     | <input type="checkbox"/> Heart surgery    | <input type="checkbox"/> Ear tubes                    |
| <input type="checkbox"/> Cleft lip        | <input type="checkbox"/> Hernia repair    | <input type="checkbox"/> Umbilical hernia             |
| <input type="checkbox"/> Cleft palate     | <input type="checkbox"/> Inguinal hernia  | <input type="checkbox"/> Undescended testicle surgery |
| <input type="checkbox"/> Cosmetic surgery |   |   |
| <input type="checkbox"/> Other: _____     |   |   |

**FAMILY HISTORY**

Have any family members had the following conditions? Please mark an 'X' by each condition that applies.

Vision Loss									
Thyroid Disease									
Sudden Death									
Substance Abuse									
Seizures									
Rheumatologic Disease									
Obesity									
Kidney Disease									
High Cholesterol									
High Blood Pressure									
Heart Disease									
Heart Defect									
Hearing Loss									
Eczema									
Early Death									
Diabetes									
Developmental Delay									
Depression									
Clotting Disorder									
Bleeding Problem									
Birth Defects									
Asthma									
Arthritis									
Allergy-Severe									
ADHD									
Other	→								

No Known Problems

Lives with patient?

**Family Member Name:**

**Date of Birth:**

Mother:	/ /
Father:	/ /
Sibling:	/ /
Sibling:	/ /
Maternal Gma:	
Maternal Gpa:	
Paternal Gma:	
Paternal Gpa:	
Other:	/ /

**List any other conditions (by family member):**