

David J. Abdun-Nur, M.D.
 Barry C. Hamann, M.D.
 Jason C. Pilcher, M.D.
 Tamara M. Powell, M.D.
 Richard A. Williams, M.D.
 Sennie Anderson, F.N.P.-C
 Chelsea Burchette, PA-C



741 NE 6th Street
 Grants Pass, OR 97526
 541-471-2701
 Fax 541-471-1166
 www.mvfp.com

PEDIATRIC HEALTH & HISTORY

Name: _____ DOB: _____ Date: _____

Parents Name: Father _____ Mother _____

Address: _____

Phone: _____ Email: _____

PAST SURGICAL HISTORY:

List all surgeries (including date or age when surgery done):

- _____
- _____

PAST MEDICAL HISTORY:

Circle if you have had any of the following medical problems:

ALLERGIES	MENINGITIS	CHILDHOOD ILLNESS:	OTHER ILLNESSES:
EPILEPSY (SEIZURES)	ASTHMA	MEASLES (GERMAN) (10 DAY)	_____
ANEMIA	HEART MURMUR	MUMPS	_____
SCOLIOSIS	HIVES OR ECZEMA	CHICKEN POX	_____
DIABETES		WHOOPING COUGH	_____

List all prescribed medications and dosages:

- _____
- _____

Vaccinations: Date of last Tetanus _____ Polio _____ Flu Shot _____

Please bring copy of vaccination sheet

List all allergies to: Medications _____ Environment or Food _____

Do you live with both parents? _____ Who else lives in your household? _____

Places you have lived _____

What school do you attend? _____

Religious Preference _____ Active _____ Inactive _____

LIFESTYLE:

Has child ever had a drinking or drug problem? _____

How frequently does child consume alcohol? _____ Last Drink? _____

Does child smoke? _____ Packs per day _____

Did child smoke in the past? _____ Quit when? _____

Are there smokers in the house? _____

Diet: Favorite foods: _____ Least favorite foods: _____

Favorite Recreations: _____

Is child involved in sports? _____ Which Sports? _____

How much time does child spend on computer? _____ TV? _____ Video Games? _____

FAMILY MEDICAL HISTORY:

	Health	Age if Living	Age at Death	Cause of Death	Circle any diseases that any blood relatives have:	Which Relative
Father	_____	_____	_____	_____	Cancer	_____
Mother	_____	_____	_____	_____	Diabetes	_____
	_____	_____	_____	_____	High Blood Pressure	_____
	_____	_____	_____	_____	Heart Problems	_____
					Stroke	_____