MOUNTAINVIEW FAMILY PRACTICE

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

Pediatric Health History Form

Name _____ Date of birth _____ Date _____

Parent info: Father _____ DOB _____ Mother _____ DOB _____

Street address _____ City _____ State _____ Zip _____

Past Surgical History

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

Date/Age	Surgery

Past Medical History

Circle below if child has had any of the following medical problems:

Allergies/Hay Fever	Meningitis	**Childhood illnesses:**	**Other illnesses:**
Epilepsy	Asthma	Measles (German/10 day)	_____
Anemia	Heart Murmur	Mumps	_____
Scoliosis	Eczema	Chicken Pox	_____
Diabetes	Hives	Whooping Cough	_____

List all medications, vitamins, supplements, over the counter medications (with dosage):

☐ Does not take medications.

Dosage	Medication

Vaccinations (date of last):

Please bring a copy of the child's vaccination sheet

Tetanus/Tdap _____ Flu _____ Pneumonia _____

Allergies:

Medications	Environment or food

Social History:

Lives with both parents _____ Who else lives in the child's household _____

Places child has lived _____ What school does the child 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 TV _____ Video games _____ Computer _____

Family Medical History:

	Medical problems	Age	Age at death	Cause of death
Father:				
Mother:				
Other:				
Other:				

Circle diseases that any blood relatives have:	Which relative:
Cancer	
Diabetes	
High Blood Pressure	
Heart Problems	
Stroke	