Sunrise Family Clinic

Infant/Toddler History

Name: _____

Date: _____

Main reason for today's visit: □ Establish care □ Other: _____

Other concerns:

_____

List all MEDICATIONS AND SUPPLEMENTS (eg. vitamins, over the counter medications):

□ **NONE**

NAME and STRENGTH	REASON taken	FREQUENCY taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy: _____

ALLERGIES: □ None known

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS:

Were all immunizations completed in Oregon? □ Yes □ No □ N/A

If no, what state were they completed in? _____ *Please bring a copy of immunization card as soon as possible, so we can update the Oregon State Database with out of state immunizations.*

Up to date, as far as you are aware, on all immunizations? □ Yes □ No

Date of last physical exam or well child check: □ In hospital □ Other: _____

MEDICAL HISTORY: Has your child ever had any of the following?

No	Yes		No	Yes		No	Yes	
□	□	Lung Disease	□	□	Allergies	□	□	Anemia
□	□	Stomach Problems	□	□	Neurological problems	□	□	Muscle, Joint, or Bone Problems
□	□	Head Injury/Concussion	□	□	Asthma	□	□	Inherited/Genetic Disease
□	□	Problems with blood	□	□	Birth Defects	□	□	Heart Problems/Murmur
□	□	Reflux/GERD	□	□	Hepatitis	□	□	Cancer (Type_____)
□	□	Seizures/Epilepsy	□	□	Skin Problems	□	□	Developmental Problems
□	□	Thyroid Problems	□	□	Kidney/Bladder Issues	□	□	Tuberculosis
□	□	Ear or Hearing Problems	□	□	Vision or Eye Problems			

Specifics of problems or other: _____

_____

Sunrise Family Clinic

Infant/Toddler History

Name: _____

Date: _____

SURGICAL HISTORY:

□ **NONE**

SURGERY	REASON	AGE

FAMILY HISTORY:

Relation	Alive	Age	Health Issues (Cancer, heart disease, diabetes, stroke, high blood pressure, heart attack, asthma, genetic issues, etc.)
Mother	Yes/No		
Father	Yes/No		
Grandmother (maternal)	Yes/No		
Grandfather (maternal)	Yes/No		
Grandmother (paternal)	Yes/No		
Grandfather (paternal)	Yes/No		
Brother/Sister	Yes/No		
Brother/Sister	Yes/No		
Brother/Sister	Yes/No		
Other _____	Yes/No		
Other _____	Yes/No		

SOCIAL HISTORY:

Home situation (please indicate all in household): □ Both parents □ Mother □ Father □ Relatives □ Foster parents
□ Sibling(s) age(s): _____ □ Other _____

Diet: □ Breastfeeding only □ Breast and Formula □ Formula only □ Other: _____

Stress level in home: □ Low □ Medium □ High

Recent changes at home ? □ No □ Yes _____

Does anyone at home smoke? □ No □ Yes (who? _____) Outside only? □ No □ Yes

Would you like to talk about any of the following?

□ Feeling sad or anxious □ Help with drugs or alcohol □ Quitting smoking □ Feeling unsafe