



# Westside Pediatric Clinic, P.C.

Peterkort Office • 9555 SW Barnes Road, Suite 270 • Portland, Oregon 97225  
Tanasbourne • 17895 NW Evergreen Parkway, Suite 110 • Beaverton, Oregon 97006

503-297-1025 • www.westsidepediatrics.com

Patient Name:

Last,

First Init.

HEALTH HISTORY

Dear Parent,

By filling out this questionnaire, a more complete record of your child is obtained. It also gives us a permanent history which we can refer to later. It saves your time and ours. Answer any questions you can. Don't worry about those you skip. We will discuss with you any items, which either you or we believe should be explained more fully.

Patient's Last,	First	MI	Age	Date
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### Pregnancy, Birth and Newborn

1. Did you have an illness during your pregnancy? No  Yes
2. Did the baby come on time? No  Yes
3. How old were you when the baby was born? \_\_\_\_\_ Years
4. How many times have you been pregnant? \_\_\_\_\_
5. How many hours did the labor last? \_\_\_\_\_ Hours
6. What was the birth weight? \_\_\_\_\_ lbs. \_\_\_\_\_ ozs.
7. Did your baby have any trouble starting to breath? No  Yes
8. Did the baby have any trouble while in the hospital? No  Yes

### Medical History

1. Was there severe colic or any unusual feeding problem in the first three months? No  Yes
2. Is your child's appetite usually good? No  Yes
3. Do any foods disagree with him/her? No  Yes
4. Does he/she often have diarrhea? No  Yes
5. Has constipation ever been much of a problem? No  Yes
6. Does he/she take any medicine? No  Yes
7. Has he/she had any allergies or reactions to any medicines or injections? No  Yes
8. Has he/she ever had eczema or hives? No  Yes
9. Has he/she ever had wheezing or asthma? No  Yes
10. Does he/she tend to have a stuffy nose or "constant cold"? No  Yes
11. Has your child had as many as three bouts of ear trouble? No  Yes
12. Does he/she have more than three colds or throat infections a year with fever? No  Yes
13. Does he/she hear well? No  Yes
14. Does he/she have any trouble passing urine? No  Yes
15. Has he/she ever had a convulsion or fit? No  Yes
16. Has he/she had any trouble with his/her eyes? No  Yes
17. Are there any problems with his/her teeth? No  Yes
18. Is there anything wrong with the way he or she walks? No  Yes
19. Check any of the following that your child has had:
 

<input type="checkbox"/> "Red or Hard" Measles	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> German or "3-Day" Measles	<input type="checkbox"/> Serious Accidents
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Removal of Adenoids and Tonsils	

**Other Operations:**

**Other Diseases (Explain):**

**Hospitalizations (Purpose):**

**Developmental History**

1. At what age did he/she sit alone? \_\_\_\_\_
2. At what age did he/she walk alone? \_\_\_\_\_
3. Did he/she say any words by the time he/she was eighteen months old? No  Yes
4. If you did not know your child's age, how old would you guess him to be by the way he/she acts? \_\_\_\_\_
5. Is he/she doing well in school? No  Yes
6. Does he/she get along well with other children? No  Yes
7. Circle any of the following problems which your child has:
  - Wets Bed
  - Nightmares
  - Speech Problems
  - Won't Toilet Train
  - Breath-Holding
  - Destructive
  - Wetting During the Day
  - Temper Tantrums
  - Mean to Animals
  - Nervous Habits of Any Kind

**Family History**

1. List first name, age, general health and years of education of the child's parents:

Mother

Father

2. List names, age, sex and general health of child's brothers and sisters:

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

3. Have any of your children died? No  Yes

4. Circle any of the following diseases that this child's parents, brothers, sisters, grandparents, aunts, uncles or first cousins have had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Early Death        |
| <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Inherited Diseases |
| <input type="checkbox"/> Deformities        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Seizures           |  | <input type="checkbox"/> Allergy            |

5. What doctors have taken care of your child in the past?