DOERNBECHER CHILDREN'S *Hospital*

OHSU Child Development and Rehabilitation Center
Patient Medical History

Patient name: _____

Date of birth: _____

Patient label here

Please fill out this form as fully as you can. Use more paper if needed.

Your name: _____ Date: _____

Relationship to child: _____ Who is child's legal guardian? _____

What name does your child like to be called? _____

1. What are you most concerned about?

2. When did these concerns begin?

3. What tests or treatments has your child had for these concerns?

4. What has been tried (including medicines) to help?

5. What are your child's strengths?

6. What are your goals for this visit?

Current medications, diet, other health care needs

List all medications (both from the doctor or over-the-counter) that your child is taking now.
(Use more paper if needed)

Does child take a multivitamin? ☐ Yes ☐ No Does child take fluoride? ☐ Yes ☐ No

Is child on a special diet? (explain)

Other health care needs (tracheostomy care, g-tube care, colostomy, etc.):

Has child had vision tested in the past year: ☐ Yes ☐ No Results: ☐ Passed ☐ Failed (explain)

Has child had hearing tested in the past year: ☐ Yes ☐ No Results: ☐ Passed ☐ Failed (explain)

Immunizations up-to-date? ☐ Yes ☐ No ☐ Don't know

Allergies (Please list): ☐ Medications ☐ Foods ☐ Other

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Pregnancy and birth history

Mother's age at baby's birth: _____

How many times has mother been pregnant? _____
Which pregnancy is this child? _____

Any miscarriages or terminated pregnancies?
☐ Yes ☐ No ☐ Don't know

Prenatal care started during _____ month of pregnancy

During pregnancy did the mother have:	Yes	No	Don't know
RH negative blood			
Diabetes			
High blood pressure			
Toxemia of pregnancy			
Vaginal bleeding or spotting			
Kidney or bladder infection			
Labor pains, cramping other than delivery			
High fever / flu-like illness			
Vaginal infection			
Membranes ruptured more than 24 hours before delivery			
☐ Too much or ☐ too little amniotic fluid			
Mother used prescription medications: (explain)			
Mother smoked cigarettes			
Mother drank alcohol			
Mother used recreational/street drugs: (explain)			
Mother experienced significant stress or emotional trauma			
Other serious illness / complications during pregnancy (explain):			

Delivery	Yes	No	Don't know
Induced labor			
Duration of hard labor: _____ hours			
☐ Forceps used or ☐ vacuum extraction			
Baby born breech or feet first			
Delivery by Caesarean section			
Difficult to get baby to breathe			
Twins or multiple births			
☐ Baby was early; weeks premature: _____ ☐ Baby was late; weeks postmature :_____			
Birthweight: _____ Length: _____			
Apgar score (if known): 1 minute: _____ 5 minutes: _____			
Other complications: (explain)			

After delivery baby had:	Yes	No	Don't know
Serious breathing difficulty			
Infections			
Jaundice			
I.V. or tube feedings			
Difficulty establishing feeding			
Seizures or convulsions			
Birth anomaly / anomalies (explain):			
Required a stay in Intensive Care Unit			
Baby discharged home at _____ days old			
Other concerns: (explain)			

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In first six months of life:	Yes	No	Don't know
Baby was difficult to feed			
Baby gained weight poorly			
Baby seemed too sleepy or too tired to eat			
Baby seemed "floppy" or was said to have low tone			
Baby had a lot of vomiting or excess spit up			
Baby had seizures			
Other serious illnesses/complications (explain):			

Review of systems (all ages)

Eyes, ears, nose, mouth, throat	Yes	No	Don't know
Vision or eye concerns			
Wears glasses			
Lazy eye or eye muscle difficulty			
Concerns with hearing			
Has hearing aid or cochlear implant			
Frequent ear infections			
Dental concerns			
Trouble chewing or swallowing			
Choking or gagging while feeding			
Frequent sore throats or tonsillitis			
Other concerns (explain):			

Skin	Yes	No	Don't know
Eczema or hives			
Other skin condition (explain):			

Cardio-respiratory (heart/lungs)	Yes	No	Don't know
Hayfever or asthma			
Chronic cough			
Trouble breathing			
Pneumonia			
Heart murmur or congenital heart defect			
High blood pressure			
Other concerns (explain):			

Abdominal region (stomach/intestines)	Yes	No	Don't know
Abdominal pain			
Poor appetite (picky eater)			
Spitting up frequently after eating			
Spells of vomiting			
Frequent constipation			
Frequent diarrhea			
Eating non-food items (dirt, paint)			
Hepatitis or jaundice after 1 month of age			
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Genitals/urinary tract	Yes	No	Don't know
Bed wetting			
Abnormalities of the: ☐ penis/testicles ☐ vagina/female genitals			
Urinary tract or kidney infection			
Difficulty with urination			
Daytime urinary accidents			
For girls, has menstruation begun			
For girls, difficulties with menstruation (explain):			
Other concerns: (explain):			

Muscles and bone structure	Yes	No	Don't know
Hip dysplasia or dislocation			
Foot or leg deformity			
Scoliosis or other back deformity			
Recurrent leg or back pain			
Fractures (explain):			
Slow to walk, or delayed in motor skills			
Patient stumbles and falls frequently			
Frequent muscle cramps			
Other concerns (explain):			

Nervous system	Yes	No	Don't know
Frequent headaches			
Convulsions or seizures			
Staring spells			
Muscle tics, uncontrollable twitches			

	Yes	No	Don't know
Serious head injury or unconsciousness (explain):			
Other concerns (explain):			

Hospitalizations	
Reason for hospitalization:	Date:
Reason for hospitalization:	Date:
Reason for hospitalization:	Date:

Surgical procedures	
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

Please describe other medical evaluations the patient has had (e.g., neurology, MRI, EEG, genetics, gastroenterology, etc.)	
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

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Development	Year	Month	Don't know
Rolled over			
Was able to sit without support			
Learned to crawl			
Walked independently			
Learned to climb stairs			
Learned to ride tricycle			
Learned to ride bicycle			
Started to babble (sounds like "baba" or "dada")			
Played games like "peek a boo," "pat a cake"			
Pointed to indicate wants			
Used first words other than "mama" and "dada"			
Used 2-3 word phrases			
Used sentences			
Told stories/related events			
Toilet trained during day			
Became dry at night			

Speech and language	Yes	No	Don't know
Delays in speech (sounds) / language (words)			
Voice sounds differently from other children			
Saying sounds incorrectly			
Family not understanding speech			
Others not understanding speech			
Are other languages spoken at home?			
If other languages spoken at home, which does the child understand most? _____ Speak the most? _____			

Activities of daily living	Yes	No	Don't know
Able to drink from cup without spilling			
Able to use spoon without spilling			
Puts on shirt and pants without help			
Uses toilet without help			
Takes bath or shower without help			

Behavior	Yes	No	Don't know
Child is often irritable			
Child has frequent tantrums			
Child is too active			
Child is immature, acts like a younger child			
Child does not play well with others			
Child has unusual sensitivities to sounds, textures, touch, foods			
Child seeks out things to touch, has excessive or unusual movement, puts objects in mouth or eats non-food items			
Other concerns: (explain):			

Sleep	Yes	No	Don't know
Loud snoring			
Long breathing pauses during sleep			
Difficulty falling asleep			
Nightime waking/trouble staying asleep			
Nightmares/night terrors			
Other concerns: (explain):			

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Family/social history *(please complete each field and list all members of your family)*

☐ **Check if child is adopted and list birth country:** _____ **and age at adoption:** _____

Name (add last name if different from patient)	Relationship	Age	School grade completed	Any medical, mental health, or school/learning concerns?	Lives in child's home?
	Biological mother				
	Biological father				

Parents' current jobs:

Please list everyone living in the home (step-parent, step-sibling, foster child, uncle, family friend, grandparent, etc.):

Please list any other family members with similar medical or mental health conditions:

Events that happen in the family or home can sometimes have an effect on a person's behavior and learning.

☐ **Check here if you would rather answer this part of the form in person**

Please check if any of the following have been experienced by the family or patient:

- ☐ Someone living in home has a serious health problem
- ☐ A parent has emotional or mental health illness
- ☐ Conflict between parents about parenting
- ☐ Involvement with juvenile court or justice system
- ☐ Recent birth/adoption of another child
- ☐ Running out of food/lack of money to buy food
- ☐ Involvement with social services/ child protective services
- ☐ Separation from parent or out-of-home placement
- ☐ Documentation concerns (immigration)
- ☐ Parent/child conflict
- ☐ Custody disagreement
- ☐ Financial problems
- ☐ Significant sibling conflict
- ☐ Single parent family
- ☐ Foster care placement
- ☐ Abandonment by parent
- ☐ Parent substance/alcohol abuse
- ☐ Unstable housing
- ☐ Exposure to domestic/physical violence in the home
- ☐ Hospitalization for a serious illness
- ☐ Death of parent or sibling
- ☐ Long military deployment of parent
- ☐ Treatment by counselor, psychologist, or psychiatrist
- ☐ Participated in behavior or parent training
- ☐ Neglect
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Separation
- ☐ Divorce

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Child care and education

Does your child go to a child care program? ☐ Yes ☐ No If yes, where?

Does your child go to an early intervention or special education program? ☐ Yes ☐ No

Where?

Does your child go to school or preschool? ☐ Yes ☐ No

Name of the school/program: Current grade:

Has your child repeated any grades? ☐ Yes ☐ No

Does your child receive extra help at school or in the community (check all that apply) :

☐ Learning center / resource room ☐ Occupational therapy ☐ Behavioral plan

☐ Speech therapy ☐ Physical therapy ☐ Feeding plan or protocol

☐ Mental health/counseling (why and how long?): _____

☐ Other (specify): _____

Does child receive any other supports?

☐ Individualized Education Plan (IEP) ☐ 504 Plan ☐ Title I supports ☐ English Learning Class (ELL/ESL)

How do you think your child is doing in school?	Well below grade level	Slightly below grade level	At grade level	Slightly above grade level	Well above grade level
Math					
Reading					
Written language					
Spelling					
Extra-curricular activities/interests?					

Health care contacts	Name	Location
Current primary care provider		
Current specialists: medical, speech, OT, PT, etc. (if any)		
Current dentist		
Current mental health provider (if any)		
Other physicians/clinics where care is received?		
Name of birth hospital		

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Additional information

Is there anything else that is important for us to know about your child?