Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

INFANT / CHILD (Birth-10 years) HEALTH HISTORY

_____ _____ _____ _____
Last Name First Name Middle Init Date of Birth

Form filled out by: ☐ Self ☐ Parent ☐ Other:_____

What is the reason(s) for your visit to our Health Center today?

Primary concern: _____

Secondary concern: _____

Additional concern: _____

Additional concern: _____

*Please note that we may not be able to address all of your concerns in a single visit. We will address concerns as visit time allows in order of medical priority. Follow-up visits may be needed to address additional concerns.

When did the problem(s) begin? _____

Have these conditions been treated another health care provider in the past? ☐ Yes ☐ No

If YES, How long ago?: _____

Provider?: _____

Where?: _____

Is the problem(s) the result of an automobile accident and/or a work injury? ☐ Yes ☐ No

If YES, specify which concern was related to this accident/injury: _____

Allergies: Do you have any allergies to the following? *(Please select all that apply)*

☐ Aspirin	☐ Bees	☐ Cats	☐ Codeine	☐ Contrast Dye	☐ Dogs
☐ Eggs	☐ Fish	☐ Latex	☐ Lidocaine	☐ Milk	☐ Mold
☐ Morphine	☐ NSAIDS	☐ Peanuts	☐ Penicillin	☐ Pollen	☐ Shellfish
☐ Soy	☐ Sulfa	☐ Sulfites	☐ Tetracycline	☐ Wheat	☐ Other: _____

Pediatric Questions:

Who lives in the home? : _____

Does anyone in your household smoke or do you spend time in any place where people smoke?	☐ Yes	☐ No
Do you always use a car seat or seatbelt?	☐ Yes	☐ No
Have you ever been tested for lead?	☐ Yes	☐ No
Do you have any concerns about your social skills?	☐ Yes	☐ No
Do you exhibit any behavioral problems?	☐ Yes	☐ No

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Pediatric Questions Continued:

Do you enjoy school? ☐ Yes ☐ No

What is your favorite subject at school? _____

Any challenges with school we should be aware of? _____

Any abuse at school or at home? ☐ Yes ☐ No

Are you having any problems with hearing? ☐ Yes ☐ No

Date of last hearing exam (if applicable)? _____

Are you having any sleeping problems? ☐ Yes ☐ No

How many times per day do you brush your teeth? : _____

Date of last dental exam (if applicable): _____

Date of last vision exam (if applicable): _____

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength	Frequency Taken and Route (oral, topical, etc.)	How long have you been taking this?

Medical Conditions: Do you currently have or have a history of the following? *(Please select all that apply)*

☐ Adrenal Disorder
☐ Anemia
☐ Anxiety
☐ Arthritis/Joint disorder
☐ Asthma
☐ Cancer
☐ COPD
☐ Depression
☐ Diabetes Mellitus
☐ Digestive Problem
☐ Heart Disease
☐ Hyperlipidemia
☐ Hypertension
☐ Other: _____
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Liver Disease
☐ Stroke
☐ Thyroid Disease

Surgeries / Hospitalizations: Have you had any of the following surgeries? *(Please select all that apply and indicate the month and year, MM/YY)*

☐ Appendectomy, Date: _____
☐ Brain Surgery, Date: _____
☐ Breast Surgery, Date: _____
☐ CABG, Date: _____
☐ Cholecystectomy, Date: _____
☐ Colon Surgery, Date: _____
☐ Cosmetic Surgery, Date: _____
☐ C-Section, Date: _____
☐ Eye Surgery, Date: _____
☐ Fracture Surgery, Date: _____
☐ Hernia Repair, Date: _____
☐ Hysterectomy, Full, Date: _____
☐ Joint Replacement, Date: _____
☐ Prostate Surgery, Date: _____
☐ Small Intestine Surgery, Date: _____
☐ Spine Surgery, Date: _____
☐ Tonsillectomy, Date: _____
☐ Tubal Ligation, Full, Date: _____
☐ Valve Replacement, Date: _____
☐ Vasectomy, Date: _____
☐ Other: _____, Date: _____

Do you have any implants, artificial joints or discs, metal or anything that could impact therapy or imaging? ☐ Yes ☐ No

If YES, please describe: _____

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Family History: Do you have a family history of any of the following? *(Please "X" the boxes that apply to you)*

	Alcohol/ Drug Addiction	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness	Stroke	Vision Problems	Gastrointestinal	Other
Mom															
Dad															
Sister															
Brother															
Mom's Mom															
Mom's Dad															
Dad's Mom															
Dad's Dad															
Mom's Sister															
Mom's Brother															
Dad's Sister															
Dad's Brother															

Immunization History: Have you had any of the following vaccines and/or illnesses? *(Please select all that apply)*

- ☐ Chicken Pox, Date: _____
- ☐ Rotavirus, Date: _____
- ☐ Hib, Date: _____
- ☐ Meningococcal, Date: _____
- ☐ Other: _____, Date: _____
- ☐ Measles, Date: _____
- ☐ Polio, Date: _____
- ☐ Pneumococcal, Date: _____
- ☐ Diphtheria, Tetanus, Pertussis (DTaP/Tdap), Date: _____
- ☐ Mumps, Date: _____
- ☐ Hepatitis B, Date: _____
- ☐ Flu (Influenza), Date: _____
- ☐ Rubella Date: _____
- ☐ Hepatitis A, Full, Date: _____
- ☐ HPV, Date: _____

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Birth / Infant History:

How were you delivered?	☐ Vaginal	☐ C-Section
Were there any complications with your birth?	☐ Yes	☐ No
Were you breast fed?	☐ Yes	☐ No

If so, for how long? _____

Gender Identity:

What is your gender identity? (Please select all that apply)

☐ Female
☐ Male
☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Female-to-Male (FTM)/Transgender Male Trans Man
☐ Additional Gender Category/(or Other)
☐ Choose not to disclose

What sex were you assigned at birth? (Please select all that apply)

☐ Female
☐ Male
☐ Unknown
☐ Not recorded on birth certificate
☐ Choose not to disclose
☐ Uncertain

Have there been any major changes in the family lately: *(Please check all that apply)*

☐ None ☐ Move ☐ Job Change ☐ Separation ☐ Divorce ☐ Death in Family

☐ Other: _____

PHQ-2: Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all
2. Feeling down, depressed, or hopeless	☐ nearly every day ☐ more than half the days	☐ several days ☐ not at all

Food Security: *Please answer the following questions regarding your social history:*

In the past year, we worried whether our food would run out before we could get more	☐ often true ☐ sometimes true	☐ never ☐ don't know /refused
In the past year, the food we bought just didn't last and we didn't have money to get more	☐ often true ☐ sometimes true	☐ never ☐ don't know /refused

Review of Systems: Please mark 'C' for any <u>current symptoms *(in the past 2 weeks)*</u>. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

<u>Constitution</u>

Fever	☐ C	☐ P	Chills	☐ C	☐ P	Weight Loss	☐ C	☐ P
Fatigue	☐ C	☐ P	Sweating	☐ C	☐ P	Weakness	☐ C	☐ P

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Review of Systems *(Continued):* Please mark 'C' for any current symptoms *(in the past 2 weeks)*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

Skin

Rash	☐ C	☐ P	Itching	☐ C	☐ P	Other	☐ C	☐ P

Head, Ears, Nose, Throat

Hearing Loss	☐ C	☐ P	Ringing in Ears	☐ C	☐ P	Ear Pain	☐ C	☐ P
Ear Discharge	☐ C	☐ P	Nosebleeds	☐ C	☐ P	Congestion	☐ C	☐ P
Sinus Pain	☐ C	☐ P	Noisy Breathing/Stridor	☐ C	☐ P	Sore Throat	☐ C	☐ P

Eyes

Blurred Vision	☐ C	☐ P	Double Vision	☐ C	☐ P	Light Sensitivity	☐ C	☐ P
Eye Pain	☐ C	☐ P	Eye Discharge	☐ C	☐ P	Eye Redness	☐ C	☐ P

Cardiovascular

Chest Pain	☐ C	☐ P	Palpitations	☐ C	☐ P	Shortness of breath lying down	☐ C	☐ P
Leg Cramping/ Claudication	☐ C	☐ P	Leg Swelling	☐ C	☐ P	PND	☐ C	☐ P

Respiratory

Cough	☐ C	☐ P	Coughing up Blood	☐ C	☐ P	Sputum	☐ C	☐ P
Shortness of Breath	☐ C	☐ P	Wheezing	☐ C	☐ P			

Gastrointestinal

Heartburn	☐ C	☐ P	Nausea	☐ C	☐ P	Vomiting	☐ C	☐ P
Abdominal Pain	☐ C	☐ P	Diarrhea	☐ C	☐ P	Constipation	☐ C	☐ P
Blood in Stool	☐ C	☐ P	Black/Tarry Stools	☐ C	☐ P			

Genitourinary

Painful Urination	☐ C	☐ P	Urgency	☐ C	☐ P	Frequency	☐ C	☐ P
Blood in Urine	☐ C	☐ P	Flank/side Pain	☐ C	☐ P			

Male Sexed

Hernias	☐ C	☐ P	Testicular Masses	☐ C	☐ P			

Female Sexed

Age of first menses: _____ Duration of menses: _____ Date of last well child exam: _____

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Review of Systems *(Continued):* Please mark 'C' for any current symptoms *(in the past 2 weeks)*. Please mark 'P' if you are not currently experiencing the symptom. *If you have had any one of these symptoms in the past, it will be captured in the history sections above.*

Musculoskeletal

Muscle Pain	☐ C	☐ P	Neck Pain	☐ C	☐ P	Back Pain	☐ C	☐ P
Joint Pain	☐ C	☐ P	Falls	☐ C	☐ P			

Endocrine/ Heme/ Allergies

Easy Bruising/ Bleeding	☐ C	☐ P	Env. Allergies	☐ C	☐ P	Excessive Thirst	☐ C	☐ P

Neurological

Dizziness	☐ C	☐ P	Headaches	☐ C	☐ P	Tingling	☐ C	☐ P
Tremor	☐ C	☐ P	Sensory Change	☐ C	☐ P	Speech Change	☐ C	☐ P
Focal Weakness	☐ C	☐ P	Seizures	☐ C	☐ P	Fainting	☐ C	☐ P

Psychiatric

Depression	☐ C	☐ P	Suicidal Ideas	☐ C	☐ P	Substance Abuse	☐ C	☐ P
Hallucinations	☐ C	☐ P	Nervous/ Anxious	☐ C	☐ P	Insomnia	☐ C	☐ P
Memory Loss	☐ C	☐ P	Other	☐ C	☐ P			