

Portland Family Practice - **Children 5 yr to 11 yr**

Dear parent, thank you for completing this form.

Please bring it with you to your child's appointment.

Patient's name: _____ **DOB:** _____

Reason for visit: _____

Accompanied by _____

Diet from the four food groups to include: Milk/dairy products? _____ Meat? _____

Grains, cereal, rice? _____ Vegetables/fruits? _____

Do you take a supplemental vitamin/fluoride daily? _____

Up to date on Vaccinations? _____

Do you wear Seat Belts in the car? _____

Do you have regular dental check-ups every 6 months? _____

Grade in school? _____ average school grades are? _____

Have you had to repeat a grade? _____

Where do you go after school? _____

Do you play any sports/activities? _____

How many hours of exercise do you get daily? _____

Do you have friends? _____ Do you get along with your siblings? _____

How many hours daily is spent watching TV, or on the computer? _____

What are your favorite things to do? _____

Are there guns in the home? _____

Exposed to second-hand smoke? _____

Current Medication(s), including vitamins, supplements/herbs –dose and quantity:

Medical History: Has your child had any of these problems:

Diabetes Cancer Asthma Bowel or Urinary problems Bleeding Disorder

Thyroid Disease Kidney Disease skin problems

Psychiatric Disorder/Depression/Anxiety motor or speech problems ADD/ADHD

Other: _____

Allergies to Medications: _____ **Other:** _____

Surgical History and dates: _____

Hospitalizations and dates: _____

-OVER-

FAMILY HISTORY:	Father	Mother	Siblings	Extended Family
DATE OF BIRTH				
Alive or Deceased				
High Cholesterol				
Heart Disease				
Hypertension				
Diabetes				
Cancer				
Stroke				
Thyroid Disease				
Kidney disease				
Bleeding disorder				
Substance Abuse				
Depression				
Psychiatric Disorder				
OTHER Diseases not listed:				

Fathers (step-Father) name: _____ or legal guardian: _____

Mothers (step-Mother) name: _____ or legal guardian: _____

Siblings name(s) and ages:

Besides parents and siblings does anyone else live in the home?

Grandparents, relative or other friends?

Social/Habit History:

Travel outside US? NO _____ Yes = where? _____

Do you use a smoke detector in your home? Yes _____ No _____

Do you have pets? _____

Do you feel safe? _____

Name/location of the pharmacy you use the most? _____

CLINIC USE ONLY

Vitals: WT _____ HT _____ HC _____ BP _____ 2nd BP _____

Pulse _____ T _____ R _____ HR _____ O2 sat _____

Vision _____ corrected _____

BP supine _____ sitting _____ standing _____

HR supine _____ sitting _____ standing _____

Review of Systems – 5 years to 11 years

Dear Parent: Please complete the following to help us provide complete care for your child.
Mark anything that has occurred in the past week or 'none of the above'.

Please give to your Medical Assistant when done, thank you.

Constitutional: weight loss eating problems sleep problems
 decreased energy none of the above

Cardiology: heart murmur chest pain decreased energy/easy fatigue
 heart racing none of the above

Ear, Nose and Throat: runny nose/congestion eye discharge ear pain or discharge
 swollen glands throat pain none of the above

Dermatology: rash(s) hair problems nail problems Eczema
 none of the above

Gastroenterology: vomiting diarrhea decreased appetite constipation
 blood in stool abdominal pain none of the above

Musculoskeletal: muscle weakness muscle pain joint pain none of the above

Respiratory: cough wheezing shortness of breath none of the above

Urology: blood in urine foul smelling urine frequent urination
 painful urination none of the above

Infectious Disease: fever(s) recent illness recent exposure to sick contacts
 none of the above

Neurology: headaches headaches vision problems
 speech problems none of the above

Hematology: easy bruising bleeding gums nose bleeds none of the above

Psychology: anxiety excess sadness concentration/attention problems
 behavior problems none of the above

PORTLAND FAMILY PRACTICE

541 NE 20th Ave. Suite 210
Portland Oregon 97232

www.portlandfp.com

Phone: 503-233-6940

Fax: 503-236-2676

Patient Contact Information:

Date: _____

Patient: _____ DOB: _____

SS#: _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

E-Mail Address: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Local Relative/Friend not living in the same household:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

By signing below, I agree I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____

(Patient)

Date: _____

(OR)

By: _____

(Patient representative)

Date: _____

Description of Representative's Authority: _____