Dorin Kemmerle, MD LLC dba Sprout Pediatrics
4350 Commercial St SE, Salem, OR 97302
(503) 877-4485 (888) 977-1263
SproutPediatrics.com

Health History (from Parent)

Today's date: _______________

Child's Name: ____ Date of birth: _______________

Birth history: Birth weight: _______________ Place of birth: ____________________________

Vaginal birth? Y / N Complications? ____

Was your child born at term? Y / N ____

Any problems after birth? Y / N Problems, smoking, alcohol, or medications while pregnant? Y / N

____

General Health: Any chronic health conditions, major illnesses, accidents, hospitalizations or surgeries? ____

Describe: ____

____

____

Current Prescription & Over-the-counter Medications, Supplements (name, dose, frequency, reason):

____

____

Drug Allergies (what drug, when & what was the reaction?) _________________________________

____

Do you consider your child to be in good health? Y / N

Are you concerned about your child's physical development? Y / N

Are you concerned about your child's mental or emotional development? Y / N

Are you concerned about your child's attention span? Y / N

Are you concerned about your child's behavior? Y / N

Is your child's ability to do things most children of the same age do limited or prevented in any way? Y / N

Does your child need or get any therapy, such as physical, occupational or speech therapy? Y / N

Does your child need or get any developmental, behavioral or emotional treatment or counseling? Y / N

Does your child need or use more medical, mental health or educational services than is usual for a child of the same age? Y / N

Do you consider your child to have special health care needs? Y / N

Past Medical History: Does your child have, or has he/she ever had:

Allergies: Past / Current ______________________

Asthma: Past / Current ______________________

Heart problems: Past / Current ________________

Anemia: Past / Current ______________________

Stomach problems: Past / Current ______________

Constipation: Past / Current ___________________

Kidney/Bladder problem: Past / Current __________

Ear problem: Past / Current ___________________

Hearing problem: Past / Current _______________

Vision/Eye problems: Past / Current ____________

Skin problem: Past / Current __________________

Developmental problem: Past / Current __________

Endocrine problem: Past / Current ______________

Neurologic problem: Past / Current _____________

Muscle problem: Past / Current ________________

Bone problem: Past / Current _________________

Headaches: Past / Current ____________________

Depression: Past / Current ____________________

Anxiety: Past / Current ______________________

Significant infection: Past / Current ____________

Chicken pox: Y / N

First menstruation? Y / N / NA When? ___________

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Previous Physician: ____
Last well child check: ____
Vaccinations up to date? : Y / N / Not sure Any vaccines received outside of Oregon? Y / N
Does your child have a dentist? Y / N Name: ____
When was the last cleaning & exam? ____
Does your child have any additional health care providers, such as therapists, naturopaths, chiropractors?
____
Does your child have food restrictions? Y / N What? ____
Why? ____
Does your child get moderate to hard exercise: Daily? Several times a week? Weekly? Less often?
Does your child regularly: eat fruit? Y / N eat vegetables? Y / N drink water? Y / N drink milk? Y / N
How often does your child eat fast /junk food? Rarely A few times a month Several times a week
How often does your child have sugary drinks? Rarely A few times a month Several times a week
Any caffeinated drinks? Sodas Coffee Energy drinks
Has your child's weight changed significantly or not as expected? ______________________________

Social, Educational & Safety history:

With whom does your child live? ____
School: ____ Grade: __________________________
Any concerns? ____
Are you concerned about your child's academic progress? Y / N __________________________________
Does he/she have an IEP or 504 plan? Y / N ____
Activities: ____
____
Religious/spiritual affiliation? __________________________ Pets?_____________________________
Are there firearms in your house? Y / N How are they & any ammunition stored? ________________
Does anyone at home smoke? Inside? Y / N Outside? Y / N In the car? Y / N
Does anyone else smoke around your child? Y / N ____
Does your child spend time where someone smokes indoors? Y / N _____________________________
Does your child use sunscreen? Y / N Does your child wear a helmet to bike, skate, ride & ski? Y / N
What variety of carseat/belt does your child use currently? _________________________________
Do you have specific health goals for your child? ____
____
____
What are your child's greatest challenges? ____
____
____
What are your child's greatest strengths? ____
____
____
Anything else you want me to know about your child? ______________________________________
____

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Family History: If any family members have had the following conditions, please list whom:

Allergies: ______________________________________
Breathing problem: ____________________________
Obesity: ______________________________________
Diabetes: ______________________________________
High blood pressure: ___________________________
High cholesterol: _______________________________
Heart disease before age 50: ____________________
Stroke: _______________________________________
Blood problem: _________________________________
Anemia: _______________________________________
Liver problem: __________________________________
Gastrointestinal problems: _______________________
Bed wetting after 5 years old: ___________________
Kidney problem: ________________________________
Hearing problem: _______________________________
Vision or eye problems: _________________________

Skin problem: _________________________________
Developmental problem: _______________________
Learning problem: _____________________________
Neurologic problem: ___________________________
Headaches: ____________________________________
Depression/Suicide: ____________________________
Other mental illness: ___________________________
Alcohol abuse: ________________________________
Drug use: _____________________________________
Autoimmune disease: __________________________
Thyroid problems: _____________________________
Genetic disorder: ______________________________
Cancer: _______________________________________
Significant infection: ___________________________
Accidental/unexplained death: __________________
Other: ____
____

Pharmacy preferences:

Local: ____
Mail Order: ____