Oregon Health & Science University
Hospitals and Clinics
Department of Dermatology

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

PEDIATRIC DERMATOLOGY HEALTH HISTORY

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Name _____ Med. Record #: _____ Birthdate _____

Home Telephone:_____ Work Telephone: _____

Grade (if in School): _____ Contact Person for Child's Appointments: _____

Referring Physician: _____
Name Address (or City) Telephone #

Primary Care Physician: _____
Name Address (or City) Telephone #

Pharmacy: _____
Name Address (or City) Telephone #

REASON FOR VISIT: _____

Any other skin concerns that need to be addressed today: _____

List Your Medications

(include over the counter, creams & Topicals and naturopathic medications)

1. _____
2. _____
3. _____
4. _____
5. _____

Is your child currently taking aspirin, Motrin, Advil, Coumadin or Vitamin E?

Yes ☐ No ☐ off _____ days

What allergies do you have to Medications OR Foods?

1. _____
2. _____
3. _____

Allergies to Latex: Yes ☐ No ☐
Allergy to Lidocaine: Yes ☐ No ☐

Describe or Other Comments:

_____
_____
_____

SOCIAL HISTORY:

Parents or legal guardian names and occupations: _____

Number of people living in household: _____ Siblings names and ages: _____

_____

Child's Activities / Sports _____

Smokers in Household? Yes ☐ No ☐

Immunization up to date? Yes ☐ No ☐

Pets in Household? Yes ☐ No ☐ Type? _____

OC4501

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Continued from page 1

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DEVELOPMENT:
Birth history (problems with pregnancy, on time vs. premature delivery, birth weight): _____

Has your child's growth (height, weight), gross motor, and language development been in the normal range?

_____

PAST MEDICAL HISTORY: Any Comments?

Skin

Birthmarks	Yes ☐ No ☐	_____
Dry/sensitive skin	Yes ☐ No ☐	_____
Eczema	Yes ☐ No ☐	_____
Keloids (thick scars)	Yes ☐ No ☐	_____
Skin cancer (including melanoma)	Yes ☐ No ☐	_____
Herpes (oral or genital)	Yes ☐ No ☐	_____

Respiratory

Asthma	Yes ☐ No ☐	_____
Seasonal allergies/Hay fever	Yes ☐ No ☐	_____

Cardiovascular

Congenital heart problems/defects	Yes ☐ No ☐	_____

Gastrointestinal

Ulcerative colitis/Crohn's disease	Yes ☐ No ☐	_____
Constipation	Yes ☐ No ☐	_____

Neurologic

Chronic headaches	Yes ☐ No ☐	_____
Seizures	Yes ☐ No ☐	_____
Depression/anxiety	Yes ☐ No ☐	_____

Endocrine:

Thyroid problems	Yes ☐ No ☐	_____
Diabetes	Yes ☐ No ☐	_____

Other

Arthritis (include type)	Yes ☐ No ☐	_____
Problems with immune system	Yes ☐ No ☐	_____
Abnormal hair/teeth/nails	Yes ☐ No ☐	_____
Frequent infections	Yes ☐ No ☐	_____
Prior surgeries or hospitalizations:	Yes ☐ No ☐	_____

FAMILY HISTORY:
Birthmarks _____
Skin disease (e.g. psoriasis, eczema, acne, athlete's foot) _____
Skin cancer (and what type, if known) _____
Bleeding disorders: _____
Asthma, hay fever _____
Hair/tooth/nail problems _____
Seizures, mental retardation, or deafness: _____
Autoimmune disease (rheumatoid arthritis, lupus, Graves' disease, vitiligo, childhood diabetes)
_____

Is there anything else you would like to share with us about your child's history?

_____

Reviewed by _____ Date _____