National Center of Medical Home
Initiatives for Children with Special Needs
Oregon Medical Home Project

Medical History

Name: _____ Birthdate: _____

Address: _____ Social Security #:

_____ _____

City: _____ Zip: _____

Telephone: _____

Parents/Primary Caregiver

Name	Address/City/Zip	Telephone	Relationship
		Day: Evening:	
		Day: Evening:	

Insurance Information **Primary Insurance** **Secondary Insurance**

_____ _____

Telephone: _____ Telephone: _____

Subscriber #: _____ Subscriber #: _____

Group #: _____ Group #: _____

Current Conditions: _____

_____

Regular Medications: _____

_____

Occasional Medications: _____

Allergies (foods and medications: _____

Special Diets or Formula:

_____

_____

_____

Last Tetanus Shot: _____ Last TB Test: _____

Immunizations up-to-date: _____ yes _____ no

Medical/Surgical History

Date	Diagnosis/Condition	Procedure	Doctor

Medical/Surgical History (Continued)

Date	Diagnosis/Condition	Procedure	Doctor