Port Gamble S'Klallam Tribal Health Clinic
Pediatric Health History

Today's Date___/___/____ Patient Name ____________________________________ Date of Birth ___/___/____
Allergies____

Birth History

Term of Pregnancy _____________Type of delivery ________________ APGARS ____/____ Birth weight_______
Length___________ Head Circ__________ Any Complications____
Place of birth ____ City _________________________ State _______
Hep B in Hospital? Yes___ No___ Date ___________ Circumcision Yes___ No___

Medical Surgical History

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Family History

Diabetes Yes___ No___ Comments ____
Heart Disease Yes___ No___ Comments ____
Obesity Yes___ No___ Comments ____
Alcoholism Yes___ No___ Comments ____
Asthma Yes___ No___ Comments ____
Allergies Yes___ No___ Comments ____
Tuberculosis Yes___ No___ Comments ____
Blood Disease Yes___ No___ Comments ____
Seizures Yes___ No___ Comments ____

Family

Name	Relation	DOB / Age	Name	Relation	DOB / Age

Developmental History

Milestone	Age	Comments
Held up head		
Smiled		
Stood alone		
Crawled		
Walked		
Words		
Sentences		
Teeth		
Toilet trained		
School Grade		
Bicycle		

Home Environment: Tobacco Exposure? ________ Heat Source_____________ Pets_____________ Other _____
Fluoride in Water? _____ Fluoride Supplement? _____ Seatbelt or Car seat? ______________
Guns in home? _____ Locked? _______

Primary Provider

_____Port Gamble S'Klallam Tribal Clinic
_____ Other ____