Patient Information

Name Date

Address

Home Phone Alternate Phone

Date of Birth Age

Parent/Guardian Information

Name Relation

Home Phone Alternate Phone

Email

Referred by

Other Health Care Providers

Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone

Medical Concerns

List your child's primary health concerns, in order of importance. Please describe their onset, how long they have been experiencing them, and any other useful information in the space provided below.

1.

2.

3.

Medical History

Please list any serious conditions, illnesses, injuries, and hospitalizations below, along with their approximate dates.

Date	*Condition, illness, injury, or hospitalization*

How would you rate your child's current health? Excellent Good Fair Poor

Does your child get regular screening done by another doctor? Yes No

If your child has any allergies, please list them below.

List all medications your child is currently taking.

Name	*Dose*	*Reason*

List all supplements your child is currently taking.

Name	*Dose*	*Reason*

List all past prescription medications your child has taken.

Name	*Dose*	*Reason*

Prenatal History

During pregnancy did Mother suffer from any of the following?

alcohol/drug use *bleeding* *diabetes* *high blood pressure*
infection *nausea* *vomiting* *thyroid problems*
other

Mother's age at pregnancy

How long was the pregnancy in weeks?

Number of previous pregnancies

Number of previous miscarriages

During the pregnancy was there any physical or emotional trauma?
Please explain.

Was there any exposure to disease during pregnancy?
Please explain.

During pregnancy did Mother travel?
If so, where?

List all medications and supplements taken during pregnancy.

Name	*Dose*	*Reason*

Labour History

Where did the birth take place?

How many hours was the labour?

During labour which interventions were applied?

C-section *epidural* *episiotomy* *forceps*
induction *pain medication* *pitocin* *vacuum extraction*
other

Newborn History

Weight

Length

Head circumference

APGAR score: birth 1 minute 5 minutes

Did your infant suffer from any of the following conditions?

anemia *colic* *congenital defect* *infection*
jaundice *poor feeding* *respiratory distress* *rashes*
other

Nutritional History

Was the infant breast fed? If so, for how long?

Was the infant formula fed? If so, which formula?

At what age was solid food introduced?

Which foods were introduced first?

Are there any foods that are excluded from the child's diet? If so, explain.

Vaccination History

Has the patient been given any of the following vaccinations?

chicken pox *diphtheria* *flu shot* *hepatitis*
measles *mumps* *pertussis* *polio*
reubella *tetanus* *other*

Has the child had any adverse reactions to any of the vaccinations they have received? If so, explain.

Dietary Factors

Describe a typical day's food and beverage intake:

Breakfast

Lunch

Dinner

Snacks

Beverages

Family History

Indicate illnesses or conditions your child's close relatives suffer from.

Mother

Father

Sibling

Sibling

Sibling

Maternal Aunts

Maternal Uncles

Paternal Aunts

Paternal Uncles

Maternal Grandmother

Maternal Grandfather

Paternal Grandmother

Paternal Grandfather

Other History

Describe the patient's general school/day care performance.

What are the child's interests?

What is the child's favourite activity?

How much exercise does the child get? How often?

Does any family member smoke?

Are there any pets in the child's home? If so, what type?

Describe the child's sleep.

Has the child been diagnosed as having any learning disabilities? If so, explain.

Please describe anything that you feel is important and has not been covered.

Review of Systems

Mark the relevant conditions listed below. Mark '*Yes*' when a condition that your child currently experiences is listed. Mark '*Past*' when a condition is listed that your child has suffered from at anytime in the past. Please comment on any condition when you feel it is pertinent.

Current weight	
Weight 1 year ago	
Maximum weight	
Height	
Height 1 year ago	

	Yes	*Past*	*Comments*
Fatigue/weakness			
Fever/chills			
Skin			
Rashes			
Eczema			
Hives			
Acne (more than mild)			
Boils			
Itching			
Color change			
Lumps			
Night sweats			
Cold to the touch			
Hot to the touch			
Nail changes			
Change in Mole			
Head			
Headache			
Head injury			
Dizziness			
Eyes			
Impaired vision			
Glasses/Contacts			
Eye pain			
Tearing			
Dry			
Double vision			
Blurring			
Itching			
Redness			
Discharge			
Blind spot			
Ears			
Impaired hearing			
Earache			
Dizziness			
Vertigo			

	Yes	Past	Comments
Discharge			
Infections			
Nose & Sinuses			
Frequent colds			
Nose bleeds			
Stuffiness			
Hay fever			
Sinus problems			
Mouth & Throat			
Frequent sore throat			
Sore tongue/mouth			
Gum problems			
Hoarseness			
Cavities			
Loss of taste			
Swollen glands			
Goiter			
Pain/stiffness			
Respiratory (lungs)			
Chronic cough			
Cough up mucous			
Cough up blood			
Croup			
Wheezing			
Asthma			
Bronchitis			
Pneumonia			
Difficulty breathing			
Pain on breathing			
Shortness of breath			
Short of breath at night			
Short of breath lying down			
Tuberculosis			
Cardiovascular (heart)			
Murmurs			
Rheumatic fever			
Chest pain			
Palpitations/fluttering			
Cyanosis			
Past ECG/EKG			
Abdomen & Gastrointestinal			
Trouble swallowing			
Change in thirst			
Change in appetite			
Nausea			
Chronic vomiting			
Vomiting blood			
Blood in stool			

	Yes Past	Comments
Excessive belching or gas		
Jaundice (yellow skin/eyes)		
Indigestion		
Diarrhea		
Rectal bleeding		
Unexplained abdominal pain		
Hernias		
How many bowel movements per day?		
Urinary		
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Blood in urine		
Musculoskeletal		
Joint pain		
Joint stiffness		
Joint swelling		
Broken bones		
Muscle spasms or cramps		
Weakness		
Backache		
Neurologic		
Fainting		
Involuntary movement		
Seizures/Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of balance		
Speech problems		
Endocrine		
Heat/cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive urination		
Diabetes		
Emotional		
Depression		
Mood swings		
Anxiety or nervousness		
Tension		
Phobias		
Insomnia		
Hours of sleep your child gets each night?		
How many hours of television per day?		