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General Information

Child's name: Child's Age:
Date of first visit
Date of birth: Sex: M F

Who is filling out this form? (name and relationship):

Who does the child live with?

Guardian Contact Information

Name and relation to child:
Address:

Phone number: (home) (alternate)
Email:
Name and relation to child:
Address:

Phone number: (home) (alternate)
Email:
Please list child's **current health care providers** with their **designation** (pediatrician, family physician etc.) and **contact information**:

Do your child have any known life-threatening allergies?
If yes please list:

Pediatric Health Overview – *Comprehensive health care requires a complete picture of health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

PRIMARY HEALTH CONCERNS

In your opinion, what are your child's most important health concerns?
1._____
2._____
3._____
4._____
5._____
6._____

MEDICAL HISTORY

How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

Current medications or supplements, include dosage:

Past medications or supplements:

How many times has your child had antibiotics?

Does your child have any allergies (medications, environmental)?

Has your child ever experienced any of the following conditions? Please circle

Allergies- seasonal
Diarrhea

Allergies-environmental
Difficulty concentrating
Appendicitis
Difficulty sleeping
Ear infection
Asthma
Eczema
Bronchitis
Frequent colds
Cancer
Hay fever
Chicken pox
Head lice
Chronic Bedwetting
Hyperactivity
Chronic nose bleeds
Impetigo
Chronic Bruising
Measles
Cold sores
Meningitis
Colic
Mumps
Conjunctivitis(pink eye)
Pneumonia
Constipation
Sinusitis
Convulsions
Skin rash
Cradle Cap
Strep throat
Croup
Thrush
Diabetes
Tonsilitis
Diaper rash
Urinary tract infection
Seizures
Headaches
Failure to thrive
Whooping cough

Has your child had their vision checked?

Has you child been to the dentist?

VACCINATION HISTORY

Have you chosen to vaccinate your child?

If yes, are they on a standard schedule or delayed/spaced (circle one)

If on a customized schedule please list what vaccines, how many doses and approximate age of vaccination;

Has your child experienced any adverse reactions from a vaccination?
If yes, please describe:

FAMILY HISTORY

Have any close relatives had any of the following conditions:

[ ] Allergies
[ ] Seizures
[ ] Anemia
[ ] Stroke
[ ] Asthma
[ ] Kidney disease
[ ] Birth defects
[ ] Psoriasis
[ ] Diabetes Early Onset/Late Onset
[ ] Bleeding disorder
[ ] Depression
[ ] Cancer What type: Age of diagnosis:
[ ] Eczema
[ ] Mental illness
[ ] High blood pressure
[ ] Juvenile Arthritis
[ ] Hay fever
[ ] High cholesterol
[ ] Autoimmune disease

Do either parents or siblings have any history of chronic illness?

LIFESTYLE

Does anyone in the household smoke?

Does the child exercise regularly? How much and what form of activity?

How many hours of television/computer/videogames does your child watch each day?

PRE-NATAL HEALTH AND BIRTH HISTORY

Was the child adopted?
If so, what is the country of origin?

How old was the mother at the time of the child's birth?

Number of previous pregnancies the mother carried to term?

Any problems with conception?

Did the mother receive medical care during pregnancy?

Did the mother have any health concerns during pregnancy?

Did the mother take any prescription drugs during the pregnancy?

Did the mother have significant exposure to cigarettes, alcohol or recreational drugs during pregnancy?

Location of birth (circle one) Home Birth Center Hospital

Vaginal delivery or C-section

Did the mother receive antibiotics in labor?

Any known complications with birth?

Weight of infant at birth:

Term length of pregnancy (how many weeks):

Any health concerns for the infant at birth?

DIET HISTORY

Breast fed? How long?

Any concerns with breastfeeding/milk supply?

Formula? How long?

What type of formula was used? (milk, soy, other)

At what age was solid food first introduced?

Did your child have any reaction to the food being introduced?

Does your child have any known food allergies?

Does your child have any dietary restrictions? (eg. Religious, vegetarian, vegan)

Is there anything else you would like to comment on?