Pediatric Health Form

(To be completed by parent or legal guardian.)

1 Patient Information

Date ______________________

Child's Name ___________________________________

Address ______________________________________

City _____________ Postal Code __________

Mother's Name________________________________

Occupation ___________________________________

Employer ____________________________________

Father's Name _______________________________

Occupation ___________________________________

Employer ____________________________________

Child's Date of Birth _________________ (dd/mm/yy)

Child's Gender: **M / F** (please circle)

2 Phone Numbers

Home Phone ________________________________

Business Phone _______________ Ext __________

Cell Phone ___________________________________

Email ____

3 Purpose of Visit

What is the purpose of today's visit? _______________

____

Is this condition getting progressively worse?

____Yes ____No ____Unknown

4 Birthing History (only for children under 2)

Birth Weight _________________________ Birth Length _____________________

Present Weight _______________________ Present Height _________________

Please describe any pregnancy problems: ____

Was the birth: __ Normal Vaginal __ Breech __ Forceps
__ Cesarean __ Vacuum Extraction

Where was the birth: __ Home Birth
__ Birthing Center ________________________________
__ Hospital ______________________________________

Labour or Delivery Problems: ____

Congenital Defects/Anomalies ____________________________________

APGAR Scores ________ Was there presence at birth: __Meconium __Cyanosis (blue) __Jaundice (yellow)

Obstetrician/Midwife ___________________________ Address ______________________________________

5 Health History

Pediatrician/Family MD ___________________________ Address _____________________________________

Date and purpose of last MD visit ____

Were there any adverse reactions to immunization? ___YES ___NO If "yes", please explain ___________

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Childhood Diseases: __Measles __Chicken Pox

__ Whooping Cough __ Mumps

__ Other ____

Has this child been treated for an emergency? _YES __NO Describe ________________________________

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Surgeries ____

Medications ____

Accidents ____

Fractures/Broken Bones ____

Has this child ever suffered from:

__Allergies	__Colds/Flu	__Headaches	__Orthopedic Problem
__Anemia	__Constipation	__Heart Trouble	__Paralysis
__Arm Problems	__Convulsions	__Hyperactivity	__Poor Appetite
__Arthritis	__Diabetes	__Hypertension	__Rheumatic Fever
__Asthma	__Diarrhea	__Joint Problems	__Ruptures/Hernias
__Backaches	__Digestion Problems	__Leg Problems	__Sinus Trouble
__Bed Wetting	__Dizziness	__Muscle Twitching	__Sugar Levels
__Behavior problems	__Fainting	__Neck Problems	__Tuberculosis
__Chronic Earaches	__"Growing Pains"	__Neuritis	__Walking Problems

Is there anything else we should know about this child? ____

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I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____________________________________ _____________________________

Signature of Parent/Guardian Date

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Patient Name