Paediatric New Patient Medical Intake Form

Last name:______________________________ First name:_____________________________

Age________________ Date of Birth:____________________ Gender: □ M □ F □ Other

Personal Health Number: ____

Address: ____

City: ____________________________ Province:_________________ Postal Code:________

Parent/Guardian contact information:

Name: ____ Phone: ____________________

Name: ____ Phone: ____________________

Email Address:____

How did you hear about Dr. Halldorson?____

Would you like to receive our newsletter via email? □ Yes □ No

Contact Information for your child's other Health Care Provider(s):

Name: _____________________Profession: _______________ Phone: ____________________

Name: _____________________Profession: _______________ Phone: ____________________

Name: _____________________Profession: _______________ Phone: ____________________

Please list your child's health concern(s):

____

____

____

History of Illness:

- □ Chicken pox
- □ Measles
- □ Mumps
- □ Rubella
- □ Scarlett fever
- □ Rheumatic fever
- □ Strep throat
- □ Pneumonia
- □ Mononucleosis
- □ Ear infection
- □ Tonsillitis
- □ Others (Pleas specify) ____________________

Childhood Immunization History:

- □ DTaP
- □ IPV
- □ HiB
- □ Pneumococcal
- □ Meningococcal
- □ MMR
- □ Chicken Pox
- □ Rotavirus
- □ Influenza
- □ Hepatitis A
- □ Hepatitis B
- □ HPV

Any Reactions to Immunization? □ Yes □ No

Please list any **medications/supplements** (with dose) your child is taking:

____

____

____

____

Please list any known **allergies**:

____

____

Please list and date any **hospitalizations**, **serious injuries/conditions**, and/or **surgeries**:

____

____

____

____

Has your child used antibiotics? □ Y □ N

Neonatal history:

Birth Weight: ______________________

□ Premature □ Late □ Anemia

□ Full Term □ Jaundice □ Congenital defects

Was your child breastfed? □ Y □ N How long? ______________________

Behavioural Challenges:

□ Tantrums □ Aggression □ Bowel/urinary incontinence □ Sleep disturbances

□ Screaming □ Hyperactivity

□ Impulsiveness

Please describe your child's **average daily** diet:

Morning Afternoon Evening

Maternal Health Information:

Age at birth: ______________

Previous pregnancy: □ YES □ NO

History of miscarriage/termination: □YES □ NO

Was your child born:

□ pre-term □ full-term □ post-term □ vaginally □ c-section

Complications related to pregnancy or delivery? _________________________________

APGAR score (1min): ______ APGAR score (5min): ______

Personal and Family History

Please check off the following diseases/conditions if the child or an immediate family member has any of the following.

□ allergies/hay fever
□ asthma
□ arthritis
□ bleeding problems
□ cancer
□ depression
□ diabetes
□ eating disorders
□ epilepsy
□ heart problems
□ high blood pressure
□ kidney problems
□ psychiatric disorder
□ obesity
□ stroke
□ substance abuse
□ thyroid disease
□ tuberculosis