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NEW PATIENT CHILD QUESTIONNAIRE

NAME:_____

ADDRESS:_____

CITY_____POSTAL CODE:_____HOME PHONE:_____

DATE OF BIRTH: (D)_____(M)_____(Y)_____AGE:_____

HEIGHT:_____WEIGHT:_____

HOW DID YOU HEAR ABOUT THIS CLINIC?_____

CARE CARD NUMBER:_____

1. MAIN REASON(S) FOR ATTENDING THE CLINIC, IN ORDER OF IMPORTANCE. INDICATE WHEN THE SYMPTOMS HAVE APPEARED.

2. MEDICAL DOCTOR'S NAME:_____

3. DO YOU CONSULT OTHER HEALTH CARE PROFESSIONAL? PLEASE LIST:

4. PLEASE LIST DRUGS/MEDICATIONS CURRENTLY TAKEN:

5. PLEASE LIST DRUGS/MEDICATIONS TAKEN IN THE PAST:

6. PLEASE LIST ALL THE SUPPLEMENTS (VITAMINS, MINERALS ETC.) TAKEN:

7. WHICH OF THE FOLLOWING CONDITIONS HAS YOUR CHILD HAVE? (PLEASE CIRCLE)

ABCESSES/ALLERGIES/ANEMIA/ARTHRITIS/ASTHMA/CANCER/CHICKEN POX1COLD SORES/DIABETES

EPILEPSY/HAY FEVER/HEART DISEASE/HEPATITIS/HERPES/INFLUENZA/KIDNEY DISEASE/LEUKEMIA

MALARIA/MEASLES/MONONUCLEOSIS/MUMPS/PARASITES/PLEURISY/PNEUMONIA/RECURRENT INFECTIONS

RHEUMATIC FEVER/RUBELLA/SCARLET FEVER/SKIN DISEASE/STREP THROAT/SINUSITIS/SUNSTROKE

TONSILITIS/WARTS/WHOOPING COUGH/WORMS

8. HAS THE CHILD HAD ANY OTHER MAJOR CONDITION?

9. ARE THERE ANY OF THE PRECEEDING CONDITIONS AFTER WHICH THE CHILD HAS NEVER BEEN TOTALLY WELL SINCE OR WHICH HAVE BEEN MORE SERIOUS THAN USUAL?

10. PLEASE LIST ALL THE SURGERIES AND WHEN PERFORMED:

11. WHAT VACCINATIONS HAS YOUR CHILD HAD? ANY ADVERSE EFFECTS FROM THEM?

12. INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR COMPLAINTS HAVE AFFECTED THE FAMILY MEMBERS.

INDICATE: F=FATHER, M=MOTHER, S1=SIBLING 1, S2=SIBLING 2 ETC., PGM=PATERNAL GRAND-MOTHER MGM=MATERNAL GRAND-MOTHER, PA=PATERNAL AUNT, PU=PATERNAL UNCLE ETC...

ALCOHOLISM_____ ALLERGIES_____ ARTHRITIS_____ ASTHMA_____ CANCER_____ DEPRESSION____ DIABETES____ EPILEPSY____ GONORRHEA____ GOUT____HAYFEVER____ HEART DISEASE____ MENTAL ILLNESS____ PARALYSIS____PNEUMONIA____ SKIN DISEASE____ SYPHILIS____ TUBERCULOSIS____