Port Moody Integrated Health

PEDIATRIC PATIENT
HISTORY QUESTIONNAIRE (0-12 YEARS)

Name :(Last)_____(First)_____(Middle Initial)_____

BC Care Card #: _____ Date: _____

Date of Birth: (day) / (month) / (year) Age: _____ Gender: Female _____ Male_____

Mother's Name: _____ Father's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone # (Home): _____ Parents # Work: _____

Parent's E-mail Address: _____

How did you hear about our clinic? _____

Who referred you to our office? (name)_____(relationship)_____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS ILLNESSES

Tonsillitis	Y N	German Measles	Y N
➔ Approx. number	_____	Chicken Pox	Y N
Ear infections	Y N	Measles	Y N
➔ Approx. number	_____	Other	Y N
Rheumatic Fever	Y N	→List:	_____

Has your child had any of the following tests?	When	Where
Electroencephalogram (EEG)	_____	_____
Psychological evaluation	_____	_____
Hearing Tests	_____	_____
Speech / Language Test	_____	_____

HOSPITALIZATIONS / SURGERIES / INJURIES

What hospitalizations, surgeries, or injuries has your child had?

_____

_____

IMMUNIZATIONS

Polio	Y N	Pertussis	Y N
Tetanus Shot	Y N	Diphtheria	Y N
Measles/Mups/Rubella	Y N	Any adverse reactions	Y N
Influenza	Y N	If yes,What? _____	

ALLERGIES

Is your child hypersensitive or allergic to:

Any Drugs? _____

Any Foods? _____

Any Environmentals: _____

Breast Fed? _____ How long? _____ Formula? _____ Milk/Soy? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

REVIEW OF SYSTEMS

Y = A condition you have now N = Never had P = Significant problem in the past

Mental / Emotional

Mood swings	Y N P	Anxiety / nervousness	Y N P
Irritability	Y N P	Cries easily	Y N P
Hyperactivity	Y N P	Unusual Fears	Y N P
Introvert / extrovert	Y N P	Sleeping problems	Y N P
Motion / Car sickness	Y N P	Nightmares	Y N P

Endocrine

Heat / cold intolerance	Y N P	Fatigue	Y N P
Excessive thirst	Y N P	Excessive hunger	Y N P
Low Blood Sugar	Y N P	High Blood Sugar	Y N P

Skin

Rashes	Y N P	Eczema, Hives	Y N P
Acne, Boils	Y N P	Itching	Y N P

Head

Headaches	Y N P	Head injury	Y N P
Dizzy Spells	Y N P	High Fevers	Y N P

Eyes

Glasses or contacts	Y N P	Eye pain/strain	Y N P
Tearing or dryness	Y N P		

Ears

Impaired hearing	Y N P	Earaches	Y N P

Nose and Sinuses

Frequent colds	Y N P	Nose bleeds	Y N P
Stuffiness	Y N P	Hayfever	Y N P
Sinus problem	Y N P	Loss of smell	Y N P

Mouth and Throat

Frequent sore throat	Y N P	Canker Sours	Y N P
Breath Odour	Y N P		

Respiratory

Cough	Y N P	Wheezing	Y N P
Asthma	Y N P	Bronchitis	Y N P

	Cardiovascular		
Heart disease	Y N P	Murmurs	Y N P
	Urinary		
Frequent urination	Y N P	Bed Wetting	Y N P
	Gastrointestinal		
Belching or passing gas	Y N P	Stomach Aches	Y N P
Constipation?	Y N P	Diarrhea	Y N P
Bowel movements:	how often? _____		
	Musculoskeletal		
Joint pain or stiffness	Y N P	Broken bones	Y N P
Muscle spasms or cramps	Y N P		
	Blood/Peripheral Vascular		
Easy bleeding or bruising	Y N P	Anemia	Y N P

Is there anything about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We are honored to be of service to you and your child!