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PEDIATRIC HEALTH RECORD

Date: _______________________________ RECORD NO. ____________________________

REGARDING THE PEDIATRIC PATIENT

Name: ______________________________ Date of Birth: ______________________________
Age: __________ Gender: M F Height: _______________ Weight: ___________

Home Phone: _________________________ Address: ___________________________________
Town/City: ___________________________________ Postal Code: ______________________

PARENTS

Name: _______________________________________ Work Number: __________________
Employer: ____________________________________
Family Physician: ______________________________

REASON FOR THIS VISIT

Chief Complaint: ____

Is the problem related to: Sports MVA Injury Learning Challenges at School Pain

Other: ____

When Did the Condition Begin: ____

Is the condition aggravated by: Sitting Standing Bending Lifting Walking
Cold Dampness Other: ____

Is the condition relieved by: Bedrest Ice/Cold Heat Massage Medication
Other: ____

Is the condition: Becoming worse/more frequent Becoming better/improving
Staying the same Coming and Going

Does the condition interfere with: Sleep Daily Routine Sports School

Has this Condition occurred before: ____________________ How long ago: ______________

Other doctors consulted regarding this condition: ___________________________________

MOTHER'S PREGNANCY AND LABOUR

During pregnancy were there: Ultrasound X-ray Medication Smoking Alcohol

Experience any Illness: ____

Length of Labour: __________________________C-Section: ________________________

Aids during Labour: Epidural Pain Medication Nerve Block Anesthesia
Forceps Vacuum Extractor Suction Forceful Manual Extraction

HEALTH HISTORY

Began walking at what age: _______________Began talking at what age: ________________

Hospitalization(s): ____

Motor Vehicle Accident(s): ____

Severe Fall(s): ____

Head Injury(s): ____

Accident Prone: ____

BEHAVIOURAL HABITS

Has your child ever demonstrated?

Mood Swings   Tantrums   Head Banging   Teeth Grinding   Inability to Focus   Twitches

Problems with Eye Contact   Adverse reaction to Change   Anxiety   Shaking

Difficult in Interactions with Schoolmates/Friends   Nervous   Repetitive Movements

Handedness - Attempts to Change

NUTRITIONAL HISTORY

Wheat introduced to diet at age: ___________________ Fussy eater: ____________________

Favourite Foods: ____

Does Diet include: Dairy   Sugar   Splenda   Aspartame   Sugar-free products
Microwave Foods   Processed Foods

Percentage (%) of Diet: Cooked Foods _________________   Raw Foods _______________

Known food allergies: ____

Supplements: Vitamins   Probiotics   Essential Fatty Acids

Vaccinations

CIRCLE all received:

DPT MMR POLIO CHICKEN POX HEPATITIS B FLU SHOT

Adverse Reactions: ____

Present Medication(s): ____

Other

Further information regarding your child and their health (past, current) of which you would like the doctor to be aware: ____

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