# PEDIATRIC PATIENT INTRODUCTION

CHILD'S NAME: ______________________________________________
(LAST) (FIRST) (MIDDLE)

MOTHER'S NAME:____________________________________________
(LAST) (FIRST) (MIDDLE)

FATHER'S NAME:____________________________________________
(LAST) (FIRST) (MIDDLE)

ADDRESS:__________________________________________________

CITY/PROV:________________________POSTAL CODE:______________

ALBERTA HEALTH CARE NUMBER:___________-___________

HOME PHONE:________________MOTHER'S WORK PHONE___________
FATHER'S WORK PHONE:______________________________________
BIRTH DATE:________________AGE:______BIRTH WEIGHT:___________
CURRENT WEIGHT:___________SEX:______NO.OF SIBLINGS:__________
BIRTH LENGTH:___________CURRENT LENGTH:____________
TYPE OF BIRTH:
NORMAL VAGINAL:___FORCEPS___BREECH___CESAREAN___
HOME:___BIRTHING CENTER:___HOSPITAL:___

PROBLEMS DURING
PREGNANCY:_______________________________________________
__________________________________________________________
__________________________________________________________
PROBLEMS DURING LABOR/
DELIVERY:_________________________________________________
__________________________________________________________
__________________________________________________________

APGAR SCORES:_______ _______
WAS THERE PRESENCE AT BIRTH OF:______JAUNDICE(YELLOW)
______CYANOSIS(BLUE)

CONGENITAL ANOMALIES/DEFECTS:_______________________________
INFANT FEEDING: BREAST_____BOTTLE_____FORMULA_____
NO. OF HOURS SLEEP PER NIGHT:______
QUALITY OF SLEEP: GOOD:_____ FAIR_____ POOR_____
OBSTETRICIAN/MIDWIFE:______________________________________
(NAME) (LOCATED AT)
PEDIATRICIAN/FAMILY MD:____________________________________
(NAME) (LOCATED AT)

DATE OF LAST VISIT TO MD:______________________________________
PURPOSE:______________________________________________________
IMMUNIZATION HISTORY:_________________________________________
PURPOSE FOR CONTACTING US?____________________________________
______________________________________________________________
______________________________________________________________
OTHER DOCTORS SEEN FOR THIS CONDITION:_____N_____Y
DOCTORS' NAMES AND PRIOR TREATMENTS:__________________________
______________________________________________________________
______________________________________________________________
OTHER HEALTH PROBLEMS?________________________________________
CHECK ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS SUFFERED FROM DURINGTHE PAST SIX MONTHS:

| | | |
|---|---|---|
| EAR INFECTIONS__ | SCOLIOSIS__ | SEIZURES__ |
| CHRONIC COLDS__ | HEADACHES__ | ADHD__ |
| ASTHMA/ALLERGIES__ | DIGESTIVE PROBLEMS__ | COLIC__ |
| RECURRING FEVERS__ | GROWING / BACK PAINS__ | BED WETTING__ |
| CAR ACCIDENT__ | TEMPER TANTRUMS__ | OTHER______ |

FAMILY
HISTORY:______________________________________________________
______________________________________________________________
______________________________________________________________
NUMBER OF DOSES OF ANTIBIOTICS YOUR CHILD HAS TAKEN:
DURING THE PAST SIX MONTHS:______,
TOTAL DURING HIS/HER LIFETIME______
NUMBER OF DOSES OF OTHER PRESCRIPTION MEDICATIONS YOUR CHILD HAS TAKEN: DURING THE PAST SIX MONTHS:______,
TOTAL DURING HIS/HER LIFETIME:______
LIST:_________________________________________________________
______________________________________________________________

**AUTHORIZATION FOR CARE OF MINOR**

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD.

SIGNED:________________________DATE:___________________________

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.

SIGNED:________________________DATE:___________________________

PREGNANCY HISTORY:_____________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

DELIVERY / BIRTH HISTORY:_______________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:

______RESPOND TO SOUND

______FOLLOW AN OBJECT WITH HIS/HER EYES

______HOLD HEAD UP

______SIT ALONE

______CRAWL

______STAND

______WALK ALONE

CHILDHOOD DISEASES: ____CHICKEN POX ____MUMPS ____MEASLES ____RUBELLA ____RUBEOLA ____WHOOPING COUGH

OTHER:_________________________________________________________

PRESENT HISTORY:_______________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

SURGERY:_______________________________________________________

MEDICATIONS:___________________________________________________

ACCIDENTS:_____________________________________________________

FAMILY HISTORY:________________________________________________