fairmont pediatrics

PARENT / PATIENT INFORMATION

(There are TWO sides to this form)

_____
Appointment Date

Your Child's Name:
Date of Birth:

Parent/Guardian Information

Mother's name:
Age:
Occupation:
Mother's health problems:

Partner's Name:
Age:
Occupation:
Father's health problems:

Mother's address: (including postal code)

Partner's address: (if different)

Mother's phone
Home:
Cell:
Work:
Email:

Partner's phone
Home:
Cell:
Work:
Email:

Are parents living together? _____

If not the parent, your relationship to the child: _____

Does your child have brothers and/or sisters? Please list names, ages and health problems:

Does anyone in the household smoke?

Name of your Family Doctor:

Does your child take any regular medications?

WHY HAVE YOU BROUGHT YOUR CHILD TO OUR OFFICE AND HOW WOULD YOU LIKE US TO HELP?

(Continued)

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Medical History:
Did mother have any problems during the pregnancy with this child? Please indicate problems with a check mark

High blood pressure	_____	Alcohol	_____
Diabetes	_____	Drugs	_____
Illnesses	_____	Smoking	_____
Medications	_____	Other (Please specify)	_____

Was the baby born at the 'right time'? Premature? ___ Overdue? _____

Was the baby well at birth? _____ Birth weight _____

Did the baby have any problems in the newborn period?

Breathing? _____ Feeding? _____ Jaundice? _____

Is there is history of:

Hospitalizations?	_____	Allergies?	_____
Operations?	_____	Past Medications?	_____
Serious Illness?	_____		

Did your child have all of the recommended vaccinations to date? _____

Development: At what age did your child begin to:

Sit: _____ Walk: _____ Talk: _____

Current grade in school: _____

Any school related problems? _____

Any problems with friends: _____

Are there any problems you would prefer not to discuss in front of your child? (Please specify)