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HEALTH CLINIC

CONFIDENTIAL HEALTH & LIFESTYLE QUESTIONNAIRE

To be completed by Parent.

Name ________________________________ Date ________
Name of Parent/Guardian's: _____________________________________
Emergency contact: ______________________________________
Address _____________________________ City _________________
Province ________ Postal code _______
Home Phone #_______________ Cell # ______________
Office #_______________ ext. ________
Date of Birth: ____________ Age ___ Alberta Health Care # _____________
Sex: Male ☐ Female ☐ Height______ Weight ______

Name of Family Medical Doctor ________________________

What is your chief concern about your child's health?
____
____
____
____
____

Child's past medical history (Surgeries, Hospitalizations)
____
____
____
____
____

Immunizations (check the ones your child has had)

Measles, Mumps, Rubella ☐
Diptheria, Pertussis, tetanus ☐
Polio ☐
Influenza ☐
Smallpox☐
Hepatitis ☐

Has your child had any reactions to any immunizations? Yes ☐ No ☐

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Childhood Illnesses (please check)

Chickenpox ☐
Rheumatic fever ☐
Mumps ☐
Frequent colds ☐
Tonsillitis ☐
Measles ☐
Other ☐

Scarlet Fever ☐
Pneumonia ☐
Rubella ☐
Ear Infection ☐
Allergies ☐

____
____
____

Symptoms (use "check" for current problem)(use "P" for past problems)

Eczema ☐
Burning of Urine ☐
Nervous ☐
Nosebleeds ☐
Frequent Urination ☐
Cough ☐
Bruises easily ☐
Ear Infection ☐
Frequent Colds ☐
Sleep problems ☐

Bed wetting ☐
Diarrhea ☐
Blood in Urine ☐
Tendency to bleed ☐
Night sweats ☐
Constipation ☐
Sore throat ☐
Hair loss ☐
Fatigue ☐

Change in appetite ☐
Unusual fears ☐
Stomach issues ☐
Hearing loss ☐
Body/breath odor ☐
Unusual Fears ☐
Tendency to bleed ☐
Change in appetite ☐

Body/breath odor

Family History [please put M (Mother), F (Father), S (sibling), or G (Grandparent)]

Allergies _____
Birth defects _____
Arthritis _____
Cancer ______
Heart disease _____
Other ________________________

Diabetes _____
Hypertension _____
Mental Illness _____
Tuberculosis _____

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Prenatal History

Mother's age at childbirth: _____
Mother's health during pregnancy (check appropriate boxes)

Bleeding ☐
Hypertension ☐
Cigarette/alcohol/ drug use ☐
Illness ☐
Medications ☐
Diabetes ☐
Thyroid problems ☐
Physical or emotional trauma ☐
Nausea ☐

Other:
____
____

Birth History

Term (please check)
Full ☐ Premature ☐ Late ☐

Weight at birth : _______ Length of labour: ________
Complications:____
____
____

Was delivery by: C-Section ☐ or Vaginal birth ☐

Did your infant experience any of the following at birth or soon after?
Jaundice ☐ Seizures ☐ Birth injuries ☐
Colic ☐ Birth defects ☐ Rashes ☐
Other:
____
____

General Information:

Child's sleep pattern (first year):
____
____
____

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Food Intolerance/allergies:

____
____

Feeding:
Breast Fed ☐ How long? __________________
Formula ☐
Milk/Soy ☐

Age child began solid foods: ____________________
What were some of the first foods introduced?

____
____
____
____

Has there been any slow development in the areas of sitting/crawling/walking/speaking? If yes, describe

____
____
____
____

Diet in a typical day:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Fluids: ____

Medications/Supplements:

____
____
____

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Food Tracker

Day	Breakfast	Lunch	Dinner	Snacks
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				

Please write down everything that you eat or drink

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