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FAMILY PHARMACY & WELLNESS CENTRE

Child Medical History and System Review

Date: ___________________________

Child's Name: _______________________________Age: _____ Birth Date: ______________________

day / month / year

Parent's / Guardian's Name ____

E-mail address: ____ Medicare # ____________________

Street Address: ____

City: _______________________________ Prov: ____________ Postal Code: ____________________

Home Phone #: _____________________________ Work Phone #: ___________________________

Who referred you to this office? ____

Who is your child's pediatrician (or family Medical Doctor)? _____________________________________

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

____

What else would you like to see changed in his/her health? ____________________________________

____

Who diagnosed the condition mentioned above?

your pediatrician ☐ a specialist ☐ other ____

Please list specialists consulted for the above condition.

____

____

What was the level of health of both parents prior to conception?

Father: poor ☐ fair ☐ good ☐ excellent ☐

Mother: poor ☐ fair ☐ good ☐ excellent ☐

What was the level of health of the mother during pregnancy?

poor ☐ fair ☐ good ☐ excellent ☐

Comments:

____

____

What supplements did you take during your pregnancy?

____

Did you smoke during pregnancy? Yes ☐ No ☐

If yes, how many cigarettes per day? ____________________

Did you drink alcohol during your pregnancy? Yes ☐ No ☐

If yes, indicate beverage, amounts and frequency. ____

What medications were you on during pregnancy?

Prescribed ____

____

Over the counter ____

____

Would you say your diet during pregnancy was:

poor ☐ fair ☐ good ☐ excellent ☐

How was the birth of this child? Indicate if there were any complications.

____

____

Was the baby nursed after birth? Yes ☐ No ☐

If yes, for how long was the baby nursed? ____

What was the first liquid, apart from water, introduced after the baby was weaned (or what was he/she started on if not nursed)? ____

What solid foods were started prior to 6 months of age?

Food	At what month

What solid foods were introduced from 6 months of age to 9 months of age?

Food	At what month

What level of health did the baby have in the first six months?

poor ☐ fair ☐ good ☐ excellent ☐

Did your baby have colic?

never ☐ occasionally ☐ often ☐ severe ☐

What vaccinations has your child had?

Vaccination	Age	Adverse Reaction (?)

What was your child's first illness that was given medical attention?

Illness	Age	Treatment

What childhood diseases has your child had? Indicate if it was mild, average or severe.

	Yes / No	Age	Severity
Roseola			
Rubella (German measles)			
Rubeola (measles)			
Chicken Pox			
Mumps			
Scarlet Fever			
Pertussis (Whooping Cough)			
Strep Throat			
Impetigo			
Mononucleosis			

How many times has your child been treated with antibiotics? ______________________

List all medications your child has taken in the past. If antibiotics, please give the type.

Age	Illness	Medication	Adverse Reaction (?)

What medications is your child on now?

____

What supplements does your child take on a regular basis?

____

____

Please give a brief history of the present health concern, giving age of onset, first symptoms and present symptoms.

____

____

____

What are your observations about your child's temperament?

____

____

Was your child's physical development:

slower that average ☐ average ☐ faster than average ☐

Was your child's mental/emotional development:

slower that average ☐ average ☐ faster than average ☐

How is your child's behaviour and performance at school?

____

Are this child's natural parents:

Married ☐ Common-law ☐ Separated ☐ Divorced ☐ Remarried ☐

Does any member of the household smoke? Yes ☐ No ☐

Are there brothers and/or sisters?

Name	Age	State of health

What was the mother's emotional state during pregnancy?

Excellent ☐ stable ☐ stressed ☐ very stressed ☐

What form of heating do you have presently?

Oil ☐ electric ☐ gas ☐ wood ☐

What is the emotional climate of the child's home presently?

very stable ☐ stable ☐ stressful ☐ very stressful ☐

Family History

Please indicate the age of all relatives living and indicate the age at which any family member became deceased. (L= living, D = deceased)

Grandmother (maternal) L ____________________ D ____________________

Grandfather (maternal) L ____________________ D ____________________

Grandmother (paternal) L ____________________ D ____________________

Grandfather (paternal) L ____________________ D ____________________

Father L ____________________ D ____________________

Mother L ____________________ D ____________________

Brothers L ____________________ D ____________________

L ____________________ D ____________________

L ____________________ D ____________________

L ____________________ D ____________________

Sisters	L ________________________	D _________________________
	L ________________________	D _________________________
	L ________________________	D _________________________
	L ________________________	D _________________________

Indicate if there have been any of the following diseases in grandparents, parents, or brothers and sisters. Indicate the number of relatives who have/had the disease.

Diabetes ______	Cancer ______	Heart Disease ______
Mental Illness ______	Arthritis ______	Hypertension ______
Allergies ______	Goiter ______	Rheumatism ______
Kidney Disease ______	Stomach Disorders ______	

Do either the child's mother or father have a chronic illness? What is their general state of health?

Father: ____

Mother: ____