

## REGISTRATION FORM - PEDIATRIC

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of birth: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_ Sex: Male Female  
Address: \_\_\_\_\_  
\_\_\_\_\_ Phone: \_\_\_\_\_

### Contacts (in order of preference)

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Whom does the child live with? \_\_\_\_\_  
How did you hear about our clinic? \_\_\_\_\_

### Other health care providers (Name, specialty):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Please list you child's health concerns, in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### Medical history

How is the child's health in general?  Excellent  Good  Fair  Poor

How was the child's health in the first year?  Excellent  Good  Fair  Poor  Unknown

Please indicate any serious conditions, illnesses, injuries, and hospitalizations, along with dates.

\_\_\_\_\_  
\_\_\_\_\_

Please list any allergies (drugs, environmental, food, etc.):

\_\_\_\_\_  
\_\_\_\_\_

Please list all current medications (prescription, over-the-counter, vitamins, herbs, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Please list past prescription medications \_\_\_\_\_

Which of the following has the child had? (0 – never, 1 – mild, 2 – average, 3 – severe)

0 1 2 3 Whooping cough	0 1 2 3 Roseola	0 1 2 3 Impetigo
0 1 2 3 Measles	0 1 2 3 Scarlet fever	0 1 2 3 Mononucleosis
0 1 2 3 Chicken pox	0 1 2 3 Strep throat	0 1 2 3 Rubella (German measles)
0 1 2 3 Mumps	0 1 2 3 Ear infections	

How many times has the child had antibiotics? \_\_\_\_\_

Please indicate what immunizations the child has had:

<input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/> Haemophilus influenza B	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> “Flu” shot	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Polio	<input type="checkbox"/> Tetanus booster When?
<input type="checkbox"/> Other: _____		

Please describe any adverse reactions: \_\_\_\_\_

What screening tests has the child had (blood, hearing, vision, etc.): \_\_\_\_\_

### Prenatal health

Please indicate the health of the parents at conception?

Mother	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Unknown
Father	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Unknown

Which best describes mom’s health during pregnancy?  Excellent  Good  Fair  Poor

Mother’s age at child’s birth? \_\_\_\_\_

How was mom’s diet during pregnancy?  Excellent  Good  Fair  Poor  Unknown

Did mother receive prenatal medical care?  Yes  No  Unknown

Did the mother experience any of the following during the pregnancy:

<input type="checkbox"/> Bleeding	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Physical or emotional trauma	

Others: \_\_\_\_\_

Did the mother use any of the following during the pregnancy?

<input type="checkbox"/> Tobacco	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Recreational drugs: _____
<input type="checkbox"/> Prescription medications: _____		
<input type="checkbox"/> Over-the-counter medications: _____		
<input type="checkbox"/> Supplements: _____		
<input type="checkbox"/> Other: _____		

**Birth history**

Term length:  Full term  Premature (by \_\_\_\_\_ wks)  Late (by \_\_\_\_\_ days)

Length of labour: \_\_\_\_\_ Weight at birth: \_\_\_\_\_

Any complications? \_\_\_\_\_

Type of birth:  Vaginal  C-section  Induced  Forceps  Anesthesia used

Did the child experience any of the following at or shortly after birth?

Jaundice  Rashes  Seizures  Birth injuries \_\_\_\_\_

Birth defects \_\_\_\_\_

Other \_\_\_\_\_

**Diet**

How was the infant fed?  Breastfed (How long? \_\_\_\_\_)  Formula. Milk/Soy/Other

Does the child have any food allergies or intolerances? Please list.

\_\_\_\_\_  
\_\_\_\_\_

Does the child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

\_\_\_\_\_

**Family history**

Indicate if a close relative (parent, sibling) has had any of the following:

Allergies	Diabetes	Asthma	Kidney disease
Birth defects	Juvenile arthritis	Other	<input type="checkbox"/> I don't know the family medical history

Do either of the parents have chronic illnesses?  Yes  No If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

**Environment**

Is the child in:  school  daycare  home care  other: \_\_\_\_\_

Is the child exposed to smoke?  Yes  No Are there pets in the home?  Yes  No

Is the child regularly exposed to any toxins or other hazards (home, school, hobbies, etc.)?

\_\_\_\_\_

How is the emotional climate of the child's home? \_\_\_\_\_

Is there anything that you feel is important that has not been covered?

\_\_\_\_\_  
\_\_\_\_\_

**Thank you for taking the time to complete this registration form.**