Queenan Family Medicine and Maternity Care
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New infant/child Patient Medical History
Queenan Family Medicine and Maternity Care

Please complete this questionnaire in its entirety in order to optimize our time together in your new patient visit. Please bring your child's OHIP card to the visit for verification. Your answers to this questionnaire are confidential and will not be shared. Please try to provide as much detail as possible. Thank you for your time.

1. Full name *as it appears on your child's OHIP card*

2. Preferred name *if different from above*

3. Date of birth

4. Address *Please include town and postal code*

5. Primary telephone number with area code

6. Alternate telephone if applicable

7. E-mail address of parent/guardian, if applicable *Please see e-mail policy for appropriate use of e-mail in your medical care. If, after reading the policy, you would not like to communicate with your doctor via e-mail, please note this below.*

8. Name of parent(s)/guardian(s) *Please include name, relationship, and phone number*

9. OHIP number

10. How did you hear about Queenan Family Medicine and Maternity Care?

11. Please list any current medical problems that your child has. *If none, please indicate "none"*

12. Please list any medical problems that your child has had in the past (excluding surgeries). *If none, please indicate "none"*

13. Please list any surgeries your child has had, your child's surgeon and/or hospital (if you know), and the year when your child had the surgery (your best estimate is fine). *If none, please indicate "none"*

14. Birth history**:** Please describe any problems or complications of pregnancy with your child, labor and delivery, or the early newborn period. At what gestational age was your child born (early, at term, or post-term)? Where was your child born?

15. Please list any allergies to medications, foods, or other substances (such as latex). *If none, please indicate "none"*

16. Please list all of the medications your child currently take, the dosage, and how often you take them. *Please include any vitamins, over-the-counter (OTC) medications, and herbal/nutritional supplements you regularly use as well.*

17. Does your child have any other healthcare providers currently involved in their care? If so, please list their name and for what condition your child sees them. *If none, please indicate "none"*

18. Please describe any alternative, integrative or complementary modalities of health care you are utilizing currently, or have utilized in the past for your child's health. If any were used for a specific problem or diagnosis, please indicate the reason as well. *If none, please indicate "none"*

19. Please describe any medical problems that members of your child's family have. *Include such problems as diabetes, heart disease, allergy and asthma, mental retardation, epilepsy, growth problems, congenital anomalies, or chromosomal problems. Please list who in your family has the medical problem, along with if they are currently living or not.*

20. Vaccinations**:** Please bring a copy of your children's vaccination record, if vaccines have been given; if vaccines have not been given, please describe how you came to that decision.

21. Please describe who is in your child's household (with whom does your child live?). Do you have any concerns with the safety of your living situation?

22. Please describe the occupation(s) of your child's parent(s)/guardian(s).

23. If your child is school age, what grade are they in and what school do they attend? Is your child in daycare/afterschool care?

24. Please describe the activities your child most enjoys. What recreational activities does your child's family enjoy doing together?

25. Does anyone in your child's household smoke cigarettes/cigars? If so, do they smoke outside or inside the home?

26. Please describe any recent changes in your child's weight and any concerns you have about your child's weight. Please describe any recent fevers, chills, excessive fatigue or low energy. *If none, please indicate "none"*

27. Please describe any recent changes your child has had had in vision, hearing, ability to smell, chew, speak, or swallow? Any problem with frequent ear infections, or recurrent strep throat/tonsillitis? Any problem with recurrent nose bleeds? Any dental concerns? *If none, please indicate "none"*

28. Please describe any recent episodes of palpitations, changes in exercise tolerance, or shortness of breath? Has your child had any episodes of pneumonia, bronchiolitis, wheezing, or a chronic cough? *If none, please indicate "none"*

29. Please describe any problems your child has had in digestion, including any nausea, vomiting, abdominal pain, chronic diarrhea, chronic constipation, blood in stool, or marked change in appetite. *If none, please indicate "none"*

30. Please describe any recent problems your child has had back pain or scoliosis, joint pain or swelling, or injuries. Any problems with persistent muscle aches or weakness *If none, please indicate "none"*

31. Please describe any recent problems with headaches, dizziness, or unusual numbness or tingling sensations. *If none, please indicate "none"*

32. Does your child have any history of urinary tract infections? Do you have any other urinary concerns including toilet training/bedwetting? *If none, please indicate "none"*

33. Does your child have any problems with allergies including allergic rhinitis, eczema, or food allergies?

34. Please use this space to express any other thoughts or concerns you may have that were not addressed in the previous questions. *Thank you for taking the time to complete this important questionnaire that will help us maximize our time together.*