MURRAYVILLE FAMILY PRACTICE GROUP | child questionnaire

The purpose of this questionnaire is to ensure that your child's electronic medical record contains complete and up to date information so we can provide optimal and comprehensive care. All information provided here will be kept strictly confidential.

Last name: _____ First name: _____

Date of birth: _____ Age: _____ ☐ female ☐ male ☐ other

BC Health Care Number: _____

Address: _____

City: _____ Postal code: _____

Mother's name: _____ Father's name: _____

Home phone: _____ Cell: _____ Work: _____

Email address: _____

Previous family doctor: _____ Phone: _____ Fax: _____

School attended, if applicable: _____

MEDICAL HISTORY

Do you have any concerns as a parent?

_____

_____

Has your child ever been to the emergency department or admitted to a hospital?

_____

Describe your child's birth story:

☐ vaginal delivery ☐ caesarean section

☐ < 37 weeks ☐ 37 – 40 weeks ☐ > 40 weeks

Were there any complications before, during or after delivery?

_____

Does your child have any allergies (food, environmental or medications)?

_____

PREVENTION AND WELLNESS

How would you rate their diet? ☐ excellent ☐ good ☐ poor

How would you rate their activity level? ☐ excellent ☐ good ☐ poor

Has your son or daughter received the regularly scheduled childhood immunizations?

☐ 2 months ☐ 4 months ☐ 6 months ☐ 1 year ☐ kindergarten

FAMILY MEDICAL HISTORY

Please indicate if any family members have significant health problems.
Please include diabetes, heart disease, stroke, and cancer (specify what type).

Adopted ☐ yes ☐ no

Mother ☐ alive ☐ deceased Health history: _____

Father ☐ alive ☐ deceased Health history: _____

Maternal

Grandfather ☐ alive ☐ deceased Health history: _____

Grandmother ☐ alive ☐ deceased Health history: _____

Paternal

Grandfather ☐ alive ☐ deceased Health history: _____

Grandmother ☐ alive ☐ deceased Health history: _____

Other relatives? _____

MEDICATIONS

List your child's prescription and non-prescription medications (or attach a list):

MEDICATION NAME	*STRENGTH*	*FREQUENCY TAKEN*