POLO
HEALTH + LONGEVITY CENTRE

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All information included here will be *absolutely confidential*. If you have any questions, please ask.

Patient's Name _____ Age _____ M □ F □ Today's Date _____

Patient's Care Card Number _____ Birthday (D/M/Y) _____

Home Address _____

City _____ Province _____Postal Code _____

Who is filling out this form? (Name & Relationship) _____

PARENT/GUARDIAN(s) CONTACT

1. Name _____ Email Address _____

Home Phone _____Work Phone _____ Cell Phone _____

Relationship to Child _____

2. Name _____ Email Address _____

Home Phone _____Work Phone _____ Cell Phone _____

Relationship to Child _____

How did you hear about our clinic?_____

Do you have Extended Coverage? Yes □ No □ Do you receive MSP Premium Assistance? Yes □ No □

OTHER HEALTH CARE PROVIDERS

Medical Doctors _____Phone _____ Chiropractor _____ Phone _____

Naturopathic Physician _____Phone _____ Other _____ Phone _____

Please list your main health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

When did the problem(s) begin (be specific)? _____

Does your child have a contagious disease at this time? Yes □ No □ If yes, what? _____

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MEDICATIONS

	NOW	PAST	FREQUENCY		NOW	PAST	FREQUENCY
Antibiotics	_____	_____	_____	Aspirin	_____	_____	_____
Tylenol	_____	_____	_____	Anti-Histamine	_____	_____	_____
Ibuprofen	_____	_____	_____	Decongestants	_____	_____	_____

Other Medications _____

SUPPLEMENTS_____
_____
_____

ALLERGIES (To medications, food, pollen, or animals) _____
_____
_____

CHILDHOOD ILLNESSES

- ☐ Chicken pox
- ☐ Scarlet fever
- ☐ Mononucleosis
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Rheumatic fever
- ☐ Ear infection(s)
- ☐ Strep throat
- ☐ Tonsillitis
- ☐ Pneumonia
- ☐ Other _____

IMMUNIZATIONS

- ☐ MMR (Measles, Mumps, Rubella) Any Reactions? _____
- ☐ DPT (Diptheria, Pertussis, Tetanus) Any Reactions? _____
- ☐ Haemophilus Influenza type B (Meningitis) Any Reactions? _____
- ☐ Polio Any Reactions? _____
- ☐ Hep B (Hepatitis B) Any Reactions? _____
- Any Reactions? _____

Maternal Age _____ Birth weight _____ Term: Prenatal _____ Full term _____ Late _____

EXPERIENCED DURING PREGNANCY (Check off which ones apply):

☐ Nausea	☐ Bleeding	☐ Alcohol Consumption
☐ Stress	☐ High Blood Pressure	☐ Drugs
☐ Injury/Trauma	☐ Toxemia	☐ Smoking
☐ Illness	☐ Medications _____	☐ Other _____

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FEEDING HISTORY

Breast fed: Y / N If yes, how long?_____

Formula fed: Y / N How long and types of formula?_____

Age solids began: _____ What foods?_____

Food allergy/intolerance(s) _____ Favourite foods _____

Sample daily diet: (Typical day, including liquids)

_____

_____

_____

FAMILY HISTORY

Identify all family members who have or have had any of the following:

- ☐ Alcoholism_____
- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Birth defects _____
- ☐ Bleeding disorder _____
- ☐ Cancer of _____
- ☐ Colitis _____
- ☐ Diabetes _____
- ☐ Eczema _____
- ☐ Epilepsy _____
- ☐ Heart disease _____
- ☐ Hearing loss _____
- ☐ High Blood Pressure _____
- ☐ Hypoglycaemia _____
- ☐ Mental illness _____
- ☐ Obesity _____
- ☐ Stroke _____
- ☐ Thyroid disorder _____
- ☐ Other(s) _____

CHILDHOOD ILLNESSES

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- ☐ Scarlet fever
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- ☐ Mumps
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- ☐ Ear infection(s)
- ☐ Strep throat
- ☐ Tonsillitis
- ☐ Pneumonia
- ☐ Other _____

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PATIENT'S MEDICAL HISTORY (Check which ones apply)

Now/Past/Never		*Now/Past/Never*		
□ □ □	Allergies	□ □ □	Exposure to cigarette smoke	Others
□ □ □	Anemia	□ □ □	Fatigue	
□ □ □	Asthma	□ □ □	Frequent Infections	
□ □ □	Bedwetting	□ □ □	Headaches	Injuries/Accidents/Illnesses (Year & Cause)
□ □ □	Birth defects	□ □ □	Heart murmur	
□ □ □	Colic	□ □ □	High fever	
□ □ □	Cough/wheeze	□ □ □	Hyperactivity	
□ □ □	Croup	□ □ □	Insomnia	Hospitalizations (Year & Reason)
□ □ □	Cradle Cap	□ □ □	Jaundice	
□ □ □	Depression	□ □ □	Learning problem	
□ □ □	Diarrhea	□ □ □	Moodiness	
□ □ □	Dry Skin	□ □ □	Stuffy nose	Surgeries (Year & Type)
□ □ □	Earache(s)	□ □ □	Thrush	
□ □□	Eczema/rash	□ □ □	Vomiting spells	