PEDIATRIC (CHILD) Medical Questionnaire - NEW Patients: (Age<18yo)

MY INTAKE APPOINTMENT IS WITH DR. _____

This form is available on Elicare.ca/Forms

Please fill out this form as completely as possible and email it to info@elicare.ca or print and bring it with you. Please print legibly.

Email:		Phone Number:	
Last Name:		First Name (Legal)	
Date of Birth:		Gender:	
Address:		Personal Health Number:	
Mobile #:		Secondary Phone #	
Emergency Contact Name:		Emergency Contact Phone #:	
Emergency Contact Relation to You		Name of Guardians if different from Parents	
Name of Parents			

PAST MEDICAL HISTORY

Where were you getting your care before?	
Do you see any specialist doctors such as a pediatrician? Please list their name and specialty:	
What past medical issues do you have? (For example, asthma, skin conditions, diabetes, celiacs disease...	

SURGERIES

Surgery	Date

MEDICATIONS: What medications do you take?:

Medication Name and Dose (if known)	How do you take it?	Why?

If there are more than can fit on this form, please bring a copy of written Rxs or go to a pharmacist and have them print one out for you.

ALLERGIES

What allergies do you have?:	

FAMILY HISTORY:

Do you have any FAMILY MEMBER with a history of

● Heart attack □ No □ Yes, who:_____	● Diabetes □ No □ Yes, who:_____
● Stroke □ No □ Yes, who:_____	● Hip fractures □ No □ Yes, who:_____
● breast cancer □ No □ Yes, who:_____	● colon cancer □ No □ Yes, who:_____
● anxiety □ No □ Yes, who:_____	depression □ No □ Yes, who:_____
● suicide □ No □ Yes, who:_____	● alcohol/substance use □ No □ Yes, who_____

SOCIAL HISTORY:

Where do you attend school?	
Who lives at home with you?	
Do you have dietary restrictions?	
Are you vegetarian?	
Do you consider yourself to have a sedentary lifestyle?	
Do you have any family members in our clinic? Who are they?	
Do you have anything else you would like us to know about you?	

FOR CHILDREN FROM AGE 0 to 12

What was your birth weight?	
What was your birth length?	
What was your birth head circumference?	
How many weeks gestation were you born?	
Method of Delivery (vaginal birth, vacuum or forceps, or cesarean section)?	
Labor and Birth Complications	