Central Park Medical Clinic

New Patient Intake Information

Patient Name: _____

Preferred Name (Nickname): _____

Date of Birth (DOB): _____

Gender: Female Male

Patient's Medical History

Current diagnoses (eg: eczema, asthma, recurrent ear infections, ADHD, developmental delay, etc):

_____

_____

Other services involved in your child's care (ex: medical specialists, counselling, PT, OT, speech therapy, etc)

_____

_____

Past diagnoses (ie: something that is no longer an issue):

_____

_____

Previous hospitalizations/injuries/surgeries:

_____

_____

Current medications (prescriptions, creams, over the counter, vitamins, etc)

_____

_____

Allergies (medications, food, other) and reaction:

_____

_____

Patient's Birth History

Mother's age at child's birth: _____ Father's age at child's birth: _____

Mother's health during pregnancy (check if experienced, list details below):

_____ Abnormal lab results _____ Abnormal ultrasound results _____ Infections

_____ High blood pressure _____ Diabetes _____ Bleeding

_____ Medication use _____ Cigarette use _____ Alcohol use

_____ Drug use _____ Other:

_____

_____

Gestational age: _____ Full Term _____ Premature at _____ weeks

Delivery method: _____ Vaginal _____ C-Section reason: _____

_____ Induction _____ Forceps _____ Vacuum

Birth Weight: _____

Any complications/issues after birth (eg: needed help to breathe, jaundice, feedings issues, NICU stay etc)

_____

_____

Family History

Please list all major childhood illnesses, medical problems, health conditions, or mental health issues in family members and list relationship to patient (eg: "mother - asthma" or "diabetes in sister"). If family member is deceased, please note age at time of death.

_____

_____

_____

_____

_____

_____

_____

Family Information

Parent # 1

Name: _____ DOB: _____

Job/Occupation: _____

Private Health Coverage: _____ Yes _____ No

Parent # 2

Name: _____ DOB: _____

Job/Occupation: _____

Private Health Coverage: _____ Yes _____ No

Siblings

Name: _____ M/F Age: _____

Name: _____ M/F Age: _____

Name: _____ M/F Age: _____

Name: _____ M/F Age: _____

Name: _____ M/F Age: _____

Social History

Who lives at home with your child?

_____

Parents are: _____Together _____ Separated/Divorced

_____ Other: _____

Child Care: _____ Home _____ Daycare _____ School: Grade _____

Exposures at home:

_____ Cat _____ Dog _____ Other pet: _____

_____ Dust _____ Mould _____ Tobacco smoke _____ Other Drugs

Car Safety: _____ Rear-facing seat _____ Forward-facing seat

_____ Booster seat _____ No car seat