Child Health Summary
East Gate Health
Dore Vanden Heuvel CTCMPAO #1063
348 Bagot St., #108, Kingston ON K7K 3B7
613.545.3598

Personal Information

Child's Name	Parents'/Guardian's Names
Telephone Home/Mobile Work	Email
Home/Street Address Apt # City Province Postal Code	Sex M F Other
Date of Birth (DD/MM/YY)	Height Weight

Emergency Contact Information

First Name	Last Name
Relationship to Child	Phone

Family Doctor Name	Clinic Phone
Clinic Address	Clinic Email

www.eastgatehealth.com
eastgatehealth@gmail.com

Ongoing Health Conditions

List any of your child's ongoing conditions.

Ongoing health conditions
Allergies to any foods, drugs, or chemicals
Drug reactions
Treatments that your child has tried or is currently trying
Prescription medications
Over-the-counter medicines, vitamins, minerals, or homeopathic remedies

Past Medical History

Childhood Illnesses

Has your child had any of the following illnesses? Check all that apply.

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Pneumonia ☐ Frequent colds

☐ Tonsillitis About how many times? ____

☐ Strep throat About how many times? ____

☐ Ear infections About how many times ____

☐ Other ____________________

Vaccinations

Has your child had any of the following vaccinations? Check all that apply.

☐ Measles ☐ Mumps ☐ Pertussis ☐ Polio ☐ BCG

☐ Rubella ☐ Rheumatic fever ☐ Smallpox ☐ Tetanus ☐ Other ____

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Family History

Have any family members had any of the following conditions?
Write **M** for Mother, **F** for Father, or **G** for grandparent.

_____ Cancer: Type ____________________
_____ Heart disease
_____ Arthritis
_____ Allergies
_____ Mental illness ____________________
_____ Birth defects ____________________
_____ Diabetes
_____ High blood pressure
_____ Tuberculosis
_____ Asthma
_____ Osteoporosis
Other __________________________

Prenatal History

Natural mother's age at birth ____ Number of previous pregnancies by mother ____
Number of miscarriages, if any ____ Medications during pregnancy, if any _________________

Did the mother have any of the following conditions during pregnancy? Check all that apply.

☐ Bleeding ☐ Nausea ☐ Physical or emotional trauma ☐ Illness ☐ Hypertension
☐ High blood pressure ☐ Cigarettes, alcohol, drug consumption ☐ Diabetes

Complications during pregnancy, if any ____

Birth History

Term ☐ Full ☐ Premature ☐ Late Weight at birth ______________

Length of labour _________ Complications, if any __________________

Did your child have any of the following conditions shortly after birth? Check all that apply.

☐ Rashes ☐ Birth injuries ☐ Blue baby ☐ Jaundice ☐ Colic
☐ Fever ☐ Seizures ☐ Birth defects ☐ Cerebral palsy
☐ Other ___________________________
Child's sleeping patterns (first year) ____

Milestones

Breast fed? ☐ Yes ☐ No How long? _________

Formula? ☐ Yes ☐ No Type (milk, soy) ________

Age began eating solids ______ Which foods? ________________________

Age began sitting ________ crawling ________ walking ________ talking ________

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Sleeping

On average, how many hours of sleep does your child get every day? Include naps.

____

What time does your child go to sleep? ________ Wake up? _________

Describe any problems with sleep. ____

Eating

Does your child have any allergies or sensitivities to foods? ☐ Yes ☐ No

If yes, please describe. ____

How many times a day does your child eat? Meals ___ Times of day __________________

Snacks ___ Times of day ______________

How many half cup servings of each does your child typically eat in a day?

Fruit: Fresh ____ Dried ____ Canned ____ Vegetables: Cooked ____ Raw ____

Whole grains ____ Protein (meat, fish, cheese, beans, lentils, nuts, seeds) _____

Dairy ____ What dairy products does your child eat? __________________________________

List any of your child's relevant past medical history.

Hospitalizations
Surgeries
Prior injuries
Past medical conditions

Has your child had any of the following tests? Please provide approximate dates and any test results.

Electroencephalogram (EEG)	Psychological evaluations
Hearing tests	Speech/language tests

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Symptoms

What symptoms does your child have? Circle **C** if your child currently has the problem and **P** if he/she had it in the past.

Hives	C	P	Burning urine	C	P
Bloody urine	C	P	Frequent urination	C	P
Cries easily	C	P	Bleeding gums	C	P
Eczema	C	P	Nervous/anxious	C	P
Nose bleeds	C	P	Vomiting spells	C	P
Asthma	C	P	Acne	C	P
Anemia	C	P	Night sweats	C	P
High fevers	C	P	Jaundice	C	P
Sensitive to light	C	P	Chronic rash	C	P
Stomach aches	C	P	Diarrhea	C	P
Hearing loss	C	P	Bruises easily	C	P
Sore throats	C	P	Flat feet	C	P
Poor or no appetite	C	P	Body/breath odor	C	P
Constipation	C	P	Nightmares	C	P
Frequent colds	C	P	Bleeding tendency	C	P
Unusual fears	C	P	Wheezing	C	P
Joint pains	C	P	Excessive tiredness	C	P
Cough	C	P	Dizzy spells	C	P
Hair loss	C	P	Other ______________________	C	P

Signature of Parent/Guardian ______________________________ _________________

Date ___________________________ Relationship to child _________________

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