



RICHMOND ALTERNATIVE MEDICAL CLINIC INC.

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Dr. Martin Kwok, ND, DrTCM

PEDIATRIC PATIENT PROFILE

Date: _____

FULL NAME _____ AGE _____ BIRTHDAY ^{MM/DD/YY} _____ SEX _____

ADDRESS _____ Postal Code _____

MOTHER'S NAME _____ FATHER'S NAME _____

PREFERRED CONTACT #: _____ (cell / work / home) E-MAIL _____

NAME OF EMERGENCY CONTACT: _____ PHONE#: _____

NAME OF PRIMARY PHYSICIAN: _____ PHONE#: _____

KNOWN ALLERGIES (food, drugs, vaccines, or environmental) _____

How did you hear about the clinic? (mark one or more) Friend BCNA Yellow Pages
 Newspaper Internet others, specify: _____

Note to patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid the physician in his diagnosis and treatment. This is a confidential record, and will NOT be released unless you have authorized us to do so. Thank you.

PRESENT HEALTH CONCERNS: Please list in the order of priority to YOU.

- 1) _____
- 2) _____
- 3) _____

LIST OF MEDICATIONS (including prescription & over-the-counter drugs, vitamins, herbs, homeopathic remedies, etc.) **CURRENTLY TAKING**

- 1) _____ dosage: _____
- 2) _____ dosage: _____
- 3) _____ dosage: _____

PAST MEDICAL HISTORY

Childhood illnesses: measles rubella mumps rheumatic fever chicken pox polio
 strep throat pneumonia mononucleosis frequent ear infections
 others _____

Hospitalization (when, for what, and how long): _____

Accidents and injuries: _____

Patient Name: _____

PAST MEDICAL HISTORY (CONT'D) please check all that apply.

- All immunizations up to date (DTP: Diphtheria, Tetanus, Pertussis; POLIO: Poliomyelitis
MMR: Measles, Mumps, Rubella; HIB: Haemophilus influenza type b; HB: Hepatitis B)
- All immunization *plus additional* immunizations, please list: _____
- All immunization up to date **EXCEPT FOR: please specify** _____
- Opted out of immunization **OR** immunized for only: please specify _____

PRENATAL/BIRTH/NEONATAL/FEEDING HISTORY

Mother's health during pregnancy (check or fill in appropriate ones):

- Nausea Took X-rays High blood pressure Smoked Drank Alcohol Vaginal bleeding
- Protein in urine High blood sugar Took Medications, what were they? _____
- Age at pregnancy _____ Amount of weight gain during pregnancy _____
- Others _____

Birth place: Hospital Home Birthing center Others, where _____

Delivery process: Natural Caesarian Forceps Did you have an epidural? _____

Other complications, explain _____

Conditions at birth (check & fill in appropriate ones):

- Weight _____ Full term Premature, how many weeks? _____
- Late, how many weeks? _____ Breathing problem Cyanosis (looked blue)
- Jaundice Anemia Infections Birth defects, what? _____
- Others, explain _____

Feeding: Breast fed, for how long? _____

Formula fed, started when? _____ Which brand(s) of formula _____

At what age (in months) were these foods introduced? Fruit _____ Vegetables _____

Grains _____ Wheat products _____ Meat _____ Fish _____

Sea Foods _____ Milk _____ Egg white _____ Egg yolk _____

SOCIAL HISTORY

Parents: Married Separated Common law Divorced Widowed

Any family member smokes? N Y, Who? _____ Drinks? N Y, Who? _____

Daycare/preschool/school name _____ How much time there per week _____

Siblings: Name Age Health Problems

1) _____ _____ _____

2) _____ _____ _____

3) _____ _____ _____

FAMILY HISTORY

	Who	Comments		Who	Comments
Allergies			Asthma		
Anemia			Hepatitis		
Diabetes			Epilepsy		
Cancer			Tuberculosis		
Others					