RICHMOND ALTERNATIVE MEDICAL CLINIC INC.
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Dr. Martin Kwok, ND Dr. Carol Lin, ND

PEDIATRIC PATIENT PROFILE

Date: _____

FULL NAME _____ AGE ___ BIRTHDAY _MM/DD/YY_ SEX____
MM/DD/YY

ADDRESS _____ Postal Code _____

MOTHER'S NAME _____ Preferred Contact #: _____ (cell / work / home)

FATHER'S NAME _____ Preferred Contact #: _____ (cell / work / home)

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, specify: _____ ☐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: _____

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

- ☐ **All immunizations up to date** (DTP: Diptheria, 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					