**DR. SHANEELA SHAHID – MD, FRCPC, FAAP – CONSULTANT PEDIATRICIAN**

# New Patient Information Form – Pediatrics

Please print clearly – Thank you. Fill up the sections which are applicable

Date: _____

Patient First Name: _____ Patient Last Name: _____

Sex: Male / Female: _____ Date of Birth: _____ Place of Birth: _____

Health Care Number: _____ VC: _____ Expiry Date: _____

Current Address: _____

Family Doctor Name (if any): _____

**Birth History:**

Type of Delivery: Vaginal ( ) Breech ( ) C Section (Primary, repeat) Weeks Gestation: _____

Premature at _____ weeks

Other Pertinent Delivery Information/Resuscitation: _____

Birth Weight: _____ Length (if known): _____ Breast or Bottle Fed: _____

Discharge Weight _____ APGAR Score (if known): _____ Formula Type: _____

Circumcision: Yes / No Blood Type: _____

**Past Medical History:**

Previous Hospitalizations / Surgeries / Serious Injuries Pertinent Medical History:

_____

_____

Seizure/ Epilepsy: _____ Heart condition: _____

Infections: _____ Ear Infection: _____

Throat Infections: _____ Pneumonia: _____

Asthma: _____

Behavioral Problem(s): _____

Any Concerns regarding development: _____

Last Hearing Test: _____

Last Vision Test: _____

**Family History:**

| | Age | Medical Diseases | Occupation |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings: | _____ | _____ | |
| | _____ | _____ | |
| | _____ | _____ | |
| | _____ | _____ | |

**Family History of:**

Diabetes: _____ High Bloor Pressure: _____ Cancer: _____ Stroke: _____

Seizures/Epilepsy: _____ Bleeding Problems: _____ Arthritis: _____

Birth Defects: _____ Learning Problems: _____ Behavioral Problems: _____

**Pertinent Social History:**

Attends: Day Care ( ) Private Sitter ( ) Preschool ( ) Formal School ( )

Use of Tobacco: Patient ( ) Parent ( ) Caregivers ( )

Exposure at home/school/sitters: Molds( )Pets( )Smoke( )Fumes( )Dust( )Solvents( ) Noise( ) Carpet( )

**Medications:** (Prescription & Over the counter) – Name, Dose & Frequency: _____

_____

**Allergies:** _____

**Immunization:** All up to date ( ) If No, details please: _____

**Parents / Guardian Names:** _____

**Contact Number:** _____ **Email Address:** _____

**Signature:** _____ **Name:** _____ (Self/parent/guardian)