

**Pediatric Health Questionnaire**  
**Orleans Family Health Clinic**



Today's Date	Child's Name	DOB	Sex – M or F Gender – M or F
Mother's full name		Father's full name	
Are parents separated? Y or N		If so, who has custody?	

<b>Household Information</b>	
Please list everyone who lives in the household:	
Does anyone smoke, use drugs or abuse alcohol inside or outside of the home?	
Mother's occupation:	Father's occupation:
Is child covered by a parent's extended health insurance program? If yes, please list name of insurer:	
Which pharmacy do you use (please include address and phone number):	
What language does your child speak at home?	
Are there any cultural or family practices that you think I should know about?	

<b>Pregnancy &amp; Birth</b>	
Were there any pregnancy complications? If so, describe:	
Medications in pregnancy:	Alcohol, drug or cigarette use in pregnancy:
Was baby born premature? If so, how many weeks:	Were there any complications during the delivery?

Did baby need to go to the nursery (NICU) and if so, for what reason?
Did baby have severe jaundice that needed treatment with phototherapy (blue lights)?
What was baby's birth weight:

Current & Past Medical Issues	

Current Medications, Vitamins and Supplements (include dose)	

<b>Allergies (include reaction)</b>
Medication:
Food:
Environmental:

Immunizations:	
Is your child fully vaccinated?	If no, for what reason:
Does your child get an annual flu shot?	If no, for what reason:

School & Child Care	
What school does your child go to?	What grade are they in?
Are there any learning concerns?	Are there any social or behaviour concerns?
Does your child attend any childcare or before/after-school care? If yes, where?	