

Child's Name: _____ Child's Gender: _____ Date of Birth: _____
Mother's Name: _____ # of Brothers: _____ # of Sisters: _____ Rank: _____
Father's Name: _____ Occupation: _____
Address: _____ Who recommended you to our clinic? Friend: Family: Internet:
Province: _____ Postal Code: _____ Other: _____
E-mail address: _____ Name of person who recommended you: _____
Home Phone: _____ Cell Phone: _____

BIRTH AND DELIVERY:

Weight at Birth: _____ Current Weight: _____

Height at Birth: _____ Current Height: _____

Difficulties during pregnancy: _____

At Delivery: Normal Vaginal: Forceps: Breech: Caesarean:

At Home: At Hospital: Hospital Name: _____

Difficulties during delivery: _____

Length of labor: _____ APGAR Score : _____

At Birth was there: Jaundice: Cyanoses (blue): Congenital abnormalities:

Feeding: Breast: How Long: _____ Bottle: Type of Milk: _____

Sleeping: _____ Hous per night; His sleeping is good: Fair: Agitated:

Pediatrician of the Child: _____

Date of last visit: _____ Reason: _____

Diagnosis Given (if any): _____

Vaccination History: _____

Childhood Diseases: _____

Other: _____

REASON FOR CONSULTATION:

DECLARATION FOR ALL:

I declare that the information given on this form is complete and exact and I consent to any necessary examinations for my child.

Date: _____ Signature: _____