Waterloo Region Nurse Practitioner Led Clinic
13 Water Street North, Cambridge
123 Pioneer Drive Unit 101, Kitchener
Phone: 519-772-2322
Fax: 519-772-2323
Email: officeadmin@wrnplc.ca

Pediatric Intake From (ages 0-12)

Preferred Clinic Location: Kitchener:____ Cambridge:____

First Name:_____Last Name:_____Gender:_____

Address:_____

Parent/Guardian First Name:_____Last Name:_____

Phone number: _____

Date of Birth: _____

Health Card:_____

Does this child currently have a family physician?_____
If not, where have they been receiving health care?_____

Birth and Pregnancy:
What city was your child born in? _____

Name of hospital: _____
Birth weight: _____

Is this your child by: ☐ Birth ☐ Adoption ☐ Step-child ☐ Other: _____

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Was your child premature? **Y / N**

Were there any significant medical problems during your pregnancy?

Y / N

Were there any significant complications during labor or the baby's newborn period?

Y / N

If yes, to any of the above questions, please explain:

_____

_____

Growth and Development

Have you or your prior provider ever had any concerns about your child's growth or development (speech/language, social skills, motor skills, etc.)? **Y / N**

If yes, please explain:

_____

_____

Past History

Has your child ever:

Had any serious medical illness?
Y / N

Had a history of asthma or wheezing?
Y / N

Ever used an inhaler or nebulizer?
Y / N

Had surgery?
Y / N

Had any broken bones?
Y / N

Had any behavioral problems?
Y / N

Been hospitalized overnight?
Y / N

If yes, to any of the above, please explain:

_____

_____

_____

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Immunizations

Has your child had all of the required vaccines? **Y / N**
If not, please explain?

_____
_____

Medications

Please list current medications, vitamins, and supplements, even those used intermittently AND please bring all medications herbals supplements to the first appointment.

1. _____
2. _____
3. _____

****If more than 3 prescribed medications, please ask your pharmacist to fax us a "med check" form****

Allergies

Please list allergies or reactions to medications, vaccines or foods**:**

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____
_____	_____

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FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
High blood pressure								
High cholesterol								
Heart attack								
Diabetes								
Stroke								
Bipolar								
Schizophrenia								
Dementia								
Alcoholism								
Depression								
Breast Cancer								
Ovarian Cancer								
Colon Cancer								
Prostate Cancer								
other								

Has a family member(s) you indicated above passed away as a result of an illness?_____

_____

Form Completed by:_____ **Date:**_____

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