Dr. Kathleen Nichols - Family Practice Patient Intake Questionnaire
Child/Adolescent (Newborn to 16 yo)

This information is being collected to help us learn more about your health in order to provide you with the best possible healthcare. The information will be used to create your medical record, and will be kept confidential. Please complete the form to the best of your ability. There are three (3) pages.

Full Name: _____

Health Card #: _____Version: _____ Expiry:_____

Address: _____
_____
_____

Home Phone #: _____ Cell Phone #:_____
Work Phone #: _____
Email: _____*private information will not be sent by email
Other: _____

The best way to contact me is (circle): Home Phone Cell Phone Work Phone Other

Demographics: ☐ Male ☐ Female ☐ Transgender ☐ Other: _____

Birth date: Month: _____ Day: _____ Year: _____ Age: _____

Medical History

Who was your previous healthcare provider?: _____

Reason for leaving previous provider: _____

When did you last receive medical care? _____

Please list any specialists that you see regarding your health:

Please list any surgeries that you have had in the past:

Do you have/have you had any of the following conditions? Check all that apply:

☐ High blood pressure (or on medication)
☐ Diabetes
☐ Heart Disease
☐ History of stroke or TIA
☐ Asthma
☐ Gout
☐ Reflux/heartburn
☐ Celiac disease
☐ Cancer: (Type _____)
☐ Anxiety
☐ Migraines
☐ Eczema
☐ High cholesterol
☐ Thyroid disease (type: _____)
☐ History of heart attack
☐ History of blood clot (leg or lung)
☐ COPD
☐ Arthritis (Type: _____)
☐ Crohn's or Ulcerative Colitis
☐ Hepatitis (Type: _____)
☐ Depression
☐ Seizures
☐ Osteoporosis
☐ Psoriasis
☐ Sexually Transmitted infections (Type _____)
☐ Pregnancy (Total number _____, Live births _____, Miscarriages _____, Terminations _____)

Other medical conditions not mentioned above:

Please list all medications you are currently taking including over the counter medications (or attach list):
1.
2.
3.
4.
5.

Do you have any drug allergies? Please list drugs and what happens when given.
1.
2.
3.

Family History

Do any medical conditions run in your family (cancer, heart disease, diabetes etc)?
example: Brother (John) – colon cancer age 64

Biological Mother:

Biological Father:

Siblings (specify):

Other:

Social History

Were you born in Canada? ☐ Yes ☐ No Country of origin? _____

School: _____

Grade: _____

Parents: Please list all parents/guardians, relationship, and specify who should have access to child's medical information. [*Eg: John Smith – father – no access, Bailey Smith – grandmother - access*]

Type of residence: ☐House ☐Apartment ☐Condo ☐Shelter

Who lives in the household? (Please list):

Do you have a drug benefit plan? ☐ Yes ☐ No Which one?_____

Which pharmacy do you use? _____

Do you smoke? ☐ Yes (# per day: _____) ☐ No ☐ Exposure to 2nd hand smoke

Do you drink alcohol? ☐ Yes (# drinks/day? _____) ☐ No

Do you use marijuana? ☐ Yes ☐ No How much? _____

Do you use other recreational drugs? ☐ Yes ☐ No If yes, please specify: _____

Are vaccinations up to date? ☐Yes ☐ No ☐ Uncertain

Please bring a copy of your immunization record to your first visit if you have it.