Essex County
Nurse Practitioner-Led Clinic

Clinique dirigée par du personnel
infirmier praticien du comté d´ Essex

PERSONAL AND MEDICAL DATA FORM ( NEWBORN TO 15YRS OLD )
*Please bring completed form in with health card and Immunization record

**Thank you for your interest in becoming a client at Essex nurse Practitioner Led Clinic. The ECNPLC collects, uses and discloses personal information in compliance with the guidelines of the Personal Health Information Policy Act (PHIPA). The priority of the ECNPLC is to provide primary health care services to residents who live in Essex and surrounding communities who do not have a primary care provider. Please answer the following questions to the best of your knowledge.**

Today's date: _________________

Name (as it appears on health card) ________________________________Date of Birth: ______________

Street: _____________________________Town: ______________________Postal code: _____________

Main Phone #_______________________________ Alternate #_______________________________

Health card number ____________________________Version Code: __________Exp: ______________

Parent #1: __________________________________ P#________________________________

Parent #2: __________________________________ P#________________________________

Email of Parent: _____________________________ Pharmacy family uses: ___________________

**Do you consent to receiving email communications? This form of communication will not include any personal health information and is strictly one way. You will not be able to email us. ◯Yes ◯ NO**

Childs previous Doctor or Nurse Practitioner: ____________________________________________

Any Specialist child is seeing or has seen in past (ENT, Psychiatrist etc...)

________________________ _________________________ _____________________________

Who lives in the household ◯Mother ◯Father ◯Sister ◯ brother ◯ other? ___________________

Total # of people in home___________

BIRTH HISTORY: Is the child by: (check one) ◯Birth ◯Adoption ◯Step-child◯ Foster?

Was the pregnancy full term? Yes or No (circle one)

Were there complications with the pregnancy or delivery? If yes what___________________

How much did your child weight at birth? __________________

## GROWTH AND DEVELOPEMENT:

Have you or previous providers had any concerns with your child's development (speech, language, social skills or motor skills?) Yes or No.

If yes please explain: _________________ ________________________________________________________

## PAST MEDICAL HISTORY:

Has your child had any of the following conditions? If you check off please explain.

◯ Serious medical illness? ________________________________________________________________

◯ Asthma/wheezing/breathing problems? ____________________________________________________

◯ Hospitalization and/ or surgery? _________________________________________________________

◯ Broken bones/ injuries? _______________________________________________________________

◯ Behavior problems? __________________________________________________________________

◯ Depression or Anxiety? _______________________________________________________________

◯ Other? ______________________________________________________________________________

ALLERGIES: Please list allergies to medications, food, or environmental (dust, pollen, dogs….)

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

MEDICATIONS: Please list current medications, vitamins and supplements (even if not used every day)

Do you have any Extended Health coverage (e.g. Greenshield, Desjardins etc.)? ◯ Yes or ◯ NO

| Name | Dosage (strength& how many times day) |
|---|---|
| | |
| | |
| | |

FAMILY HISTORY: Has any of your child's blood relatives have any of following?

◯Alcoholism/ Drug use? Who______________________ ◯ High cholesterol? Who____________________

◯Cancer (who and what type) _____________________________________________________________

◯ High blood pressure? who________________________ ◯Stroke? Who___________________________

◯ Metal health problems? Who and what_____________________________________________________

◯ Bleeding /clotting disorder? Who__________________ ◯ Diabetes? Who &type____________________

◯Genetic disorder? Who & what? __________________________________________________________

◯ Asthma/ COPD? Who & which one_________________________ ◯ Other ________________________

## Diet/Exercise:

Is your child physically active? Yes or No (circle one)

How would you rate your child's diet? ◯ Good ◯ Fair ◯ Poor.

Are they picky eater? ◯Yes ◯ No

Any use of ◯Alcohol ◯Drugs or ◯ Tobacco by person this form is being filled out for?

Is the child exposed to second hand smoke in the home? Yes or No (Circle one)

Please list any information that is not on this form that you feel we should know.

Or any Health concerns.

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