MOFFAT BEACH FAMILY MEDICAL PRACTICE

Patient Health Summary - Child

Please complete the following information to help pus provide you with the best possible care

Surname: ________________________ First name: __________________________ Age: _________________

Please list all medications: (including inhalers)

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Any known allergies or sensitivity to any medication, foods or dressings:

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Any history of operations or illness:

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Immunization:

☐ Fully immunized ☐ Not fully immunized ☐ Not sure

Does your child suffer from any of the following:

☐ Poor appetite ☐ Problems with sleeping ☐ Bedwetting/soiling ☐ Frequent earache

☐ Recurrent sore throat ☐ Behavioral problems ☐ Problems at school ☐ Frequent colds

List any concerns that you would like to discuss with the doctor:

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Office use only:

Date: _____________________ Height: _______________________ Weight: _______________________

Vision: Right ____/6 Left ____/6

Colour: ☐ Pass ☐ Fail