

## Dickson-Hall Medical Consulting New Child History & information sheet

Dear Parent or Guardian,

*We'd like to extend a warm and sincere welcome to our practise!*

*We look forward to working together with you and your child in order to optimise your health and wellness.*

*Since this is your first consultation, we'd like to take the time to get to know you and your medical and family background a little better, in order to provide a more optimal and individually centred service to you and your loved ones.*

*No fields are compulsory, and there are no 'right or wrong' answers, so if you should you prefer not to answer any of the questions below, or would prefer to answer them at another consult, simply omit it / them and continue onwards with the form.*

*All information provided will be treated as confidential. If you think we need more detail on any of the fields or questions, please continue the information on the paper provided at the back of the questionnaire.*

Many thanks!

**A. Basic details and information:**

1	Title (Miss, Master)		
2	Surname		
3	First Names		
4	Calling name, for the practise to call your child as		
5	Any previous surname		
6	Date of birth		
7	Age at last birthday		
8	ID / passport no		
9	Medical Aid		
10	Medical Aid option / plan		
11	Medical Aid no		
12	Main member of Medical Aid		
13	Main members ID number		
		<b>Parent / guardian 1</b>	<b>Parent / guardian 2</b>
14	Parent / guardian name		
	Parent / guardian role		
	<u>Legal</u> Parent / guardian?		
15	Street address		
16	Email address	<i>(Large print please)</i>	<i>(Large print please)</i>
17	Cell phone no		
18	Home no		
19	Next of kin name, relation & cell no		

20	Religion	
21	Home language	

**B. Antenatal History: Did any of the following take place during the pregnancy with this child? If so, please provide detail:**

1	IVF / assisted fertility baby	
2	High blood pressure / pre-eclampsia / eclampsia / toxemia	
3	High blood sugar / diabetes	
4	Anaemia	
5	Placental insufficiency	
6	Antepartum haemorrhage / placenta previa with bleeding	
7	Uterus infection	
8	Infection in the mother (German measles, HIV, Hepatitis B/C, malaria, syphilis, TB, etc)	
9	Trauma / major accident	
10	Alcohol in pregnancy (more than 1-2 x 100ml drinks /week)	
11	Smoking in pregnancy	
12	Admission to hospital	
13	Multiple pregnancy (eg: twin, triplet, etc)	
14	Suspected abnormality (eg: heart, kidneys, spine)	
15	Other:	

**C. Birth History: Did any of the following conditions during the birth of this child? If so, please provide detail:**

1	Premature labour & birth (under 37 weeks pregnant)	
2	Foetal distress	
3	Meconium stained liquor / aspiration (baby breathed it in)	
4	Breech	
5	Baby very big or very small for age	
6	Shoulder dystocia (shoulders stuck)	
7	Cord presentation (cord delivery first)	
8	Prolonged labour	
9	Caesarean section	
10	Asphyxia (didn't breathe well after birth, needed Oxygen or ventilation)	
11	Jaundice	
12	Seizures	
13	Infection	

**D. Infant & Toddler History: Did any of the following conditions occur during the first two years of life of this child? If so, please provide detail:**

1	Pneumonia	
2	Severe gastroenteritis (needed admission)	
3	Meningitis / encephalitis	
4	Severe trauma or injury	
5	Infection (HIV, TB, etc)	

6	Malignancy (cancer)	
7	Organ dysfunction (eg: Heart, kidney)	
8	Body deformity (eg: clubbed foot) or sensory abnormality (eg: deafness)	
9	Special syndrome (eg: Down's)	
10	Thyroid disorder?	
11	Developmental delay (very slow milestone achievement)	
12	Behaviour abnormality	
13	Slow or insufficient growth	
14	Other?	

<b>Was the baby / child breastfed? If so, for how long?</b> <b>Was the baby / child fully / partially / not at all immunised?</b> <b>Who cares/d for baby / child during the day?</b> <b>Is there anyone in the household, family, close friendship circle or next door neighbourhood with TB currently, or the last year?</b> <b>Baby / child's last Vitamin A or deworming administration (if child is over 1yroid)?</b>	

**E. Medical History: Did / does your baby / child experience any of the following conditions of the body systems? If so, please provide detail:**

1	Neurological	Epilepsy, cerebral palsy
2	Endocrine	Diabetes, autoimmune conditions, thyroid disorders
3	Gastroenterological	Intussusception, Reflux, hernia, other
4	Dermatological	Rashes, Eczema, birth marks, etc
5	Cardiac	Heart or valve disorders or defects
6	Pulmonary	TB, Asthma, cystic fibrosis
7	Renal	Nephritis, Nephrotic syndrome
8	Rheumatoid	Arthritis (rheumatoid), Lupus
9	Haematological	Factor or clotting deficiencies / abnormalities, anaemia
10	Oncology	Cancers
11	Orthopaedic	Bone abnormalities or deterioration syndromes
12	Infections	HIV, Hep B / C, TB
13	Eye conditions	Squint, near / short sightedness
14	Psychiatric	Depression, Anxiety, Bipolar mood disorder, ADHD, ADD, Adjustment disorder

15	Allergies	Medication, food, latex, Elastoplast, etc
16	Other	

**F. Surgical (operations) History** (please supply date, surgeon & hospital)

1	Vascular	Trauma, grafts
2	Cardiac	Valve repairs, trauma repairs
3	Orthopaedic	Fractures (broken bones), grafts
4	Pulmonary	Chest drains
5	Neurological	Brain surgery, spinal surgery
6	Dermatology	Cancers, grafts
7	Oncology	Cancer surgeries
8	Ophthalmological	Eye operations
9	ENT	Tonsillectomy, adenoidectomy, sinusitis, ear, allergic rhinitis (hay fever)
10	Dental	tooth extractions
11	Gastroenterological	Bowel obstruction, colon resection, appendectomy
12	Renal / adrenal	Biopsy, removal
13	Urological	Frequent UTI's (bladder infections), pyelonephritis
14	Transplantation	Heart, kidney, cornea
15	Cosmetic surgery	Bat ears, etc
17	Ports / IV access	Dialysis, Chemotherapy
18	Other	

**G. Medication history:**

	Name	Dose / how often a day or week the medication is taken
1		
2		
3		
4		
5		
6		

**H. Family, household & resource history:**

1	Does any one of whom you are related by blood (mother, sister, first cousin) have any illnesses eg: Cancer, autoimmune illnesses, diabetes, asthma, epilepsy, heart problems, thyroid problems, TB, nerve or muscle diseases, cholesterol issues, osteoporosis, mental health problems?	
2	Does anyone in your immediate family (parent, guardian, children) have any major illness?	
3	Is anyone in your household currently very ill or disabled?	
4	Does anyone in your family or household have problems with alcohol or drug use?	
5	Does the child live with adults, children or adolescents with behaviour disorders or challenges?	
6	Is the household very close to electric pylons, cell phone towers, major freeways, factories or airports?	
7	Does the child currently live in more than 1 household (eg: divorced parents)? If so, what are the usual arrangements?	
8	Do you live together with special family pets? If so, please provide details.	
9	What school / crèche does your baby / child attend?	
10	Does your household have a pool / pond / stream which is unfenced? If so, can your child swim well?	
11	Does your child have a car chair / safety seat that is used on every car journey?	
12	Do you have a First Aid kit in your car & home?	

I. **Accident or trauma injury history**, eg: fall, car collision, gunshot wound, assault

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J. **Major adverse life event history**, eg: hijacking, armed robbery, interpersonal violence, witnessing a traumatic event, divorce of parent, death of parent, death of a sibling, diagnosis of a life threatening illness, emigration

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K. **Diet & intake history:**

1	Does your baby / child follow any diet, eg: vegan, vegetarian?	
2	Is your child currently on diet, eg: Weigh less?	
3	Does your child have any food allergies / sensitivities?	
4	How many times a week does your child eat fast food from a 'take out' venue?	
5	How many portions of fruit & veg does your child usually eat daily?	
6	Does your child drink coffee / coke?	
7	Does your child eat chips, white bread, fizzy cooldrinks, chocolates? If so, how frequently?	
8	What does your child usually eat for breakfast?	
9	Do you use any vitamins / supplements? If so, which ones?	
10	Do you smoke? If so, at what age did you start & how many do you smoke per day?	

11	Do you engage in recreational drug use? If so, what substances do you use & how often are you using?	
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**L. Travel history:**

1	Do you travel during the year internationally? If so, to which countries?	
2	Do you travel during the year within Africa? If so, to which countries?	
3	Do you travel during the year, to regions of Malaria risk? If so, does your child use malaria prophylaxis? What methods do you use instead or in addition to prophylaxis?	

**M. Would you like to be referred to any of the following: (Tick if 'yes')**

1	Dietician	
2	Social worker	
3	Weigh less program	
4	Baby / child sitter services	
5	Smoke enders program	
6	Psychologist (educational, behavioural, family)	
7	Support group (for any any variety of conditions / situations / illnesses)	
8	Chiropractor / physiotherapist	
9	Occupational therapist	
11	First Aid / CPR course	
12	Other:	

**N. Would you be interested in the following (Tick if 'yes'):**

1	6 monthly Vitamin A, deworming, weight / height & general wellness checks?	
2	HIV testing?	
3	Revision of your existing medication to the most cost effective generic options?	
4	Purchasing a home / car practise compiled first Aid kit?	

**O. Would you like to take advantage of the following services? (Tick if 'yes')**

1	Blood / test results SMS'd to you by the laboratory?	
2	Info relating to your illness / condition / medication emailed to you by the practise?	
3	X-Ray results relating to your condition SMS'd OR emailed to you?	
4	Courtesy laminated medical history & personal contact emergency info card for your wallet / car / child's school or crèche bag?	

**P. Is there anything else you wish to advise / inform / request of the practise?**

**Q. Please let us know who referred you to us & how did you hear about the practise?**

*Thank you for your time!*

*We look forward to partnering with you in optimising your health, today and in the future.*