the Children's Clinic
and family practice

Windward Center, 92 Smith Road
Telephone 345-949-2970
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0-16 Years Health History

Name: _____ Date of Birth: _____
Last First Middle Day / Month / Year

Mailing Address: PO Box: _____ Postal Code: _____

Street Address: _____ District: _____

Mother Name: _____

Email: _____ Tel: _____ _____ _____
(Work) (Home) (Mobile)

Occupation: _____ Place of Work: _____

Father Name: _____

Email: _____ Tel: _____ _____ _____
(Work) (Home) (Mobile)

Occupation: _____ Place of Work: _____

Insurance Company: _____ Group: _____ Policy: _____

I authorise The Children's Clinic Cayman to periodically contact me through the contact information I have hereby provided for the purpose of updating me about news and services provided by the practice.

Pregnancy / Birth Information

1. Place of Birth		
2. Type of Delivery		
3. Birth Weight		
4. Complications	Mother	Baby
5. Feeding	Breast Fed	Bottle
6. Immunisation	Up to date?	
7. Development	Any delay?	

Family Health History

Has anyone in the patient's family (parents, grandparents, siblings, aunts, uncles or cousins) experienced any of the following diseases?

	Relationship		Relationship		Relationship
Asthma		Seizures		Learning disability/problems	
Diabetes		Heart attack (under 65 yrs)		Mental illness/suicide	
Cancer		Thyroid disease		Other	
Other		Other		Other	

Previous Hospitalizations / Surgeries

Please indicate if the patient has been admitted to the hospital or has had any surgeries.

Age of Patient	Hopistal / Medical Centre	Country	Reason for Hospital Stay / Surgery / Procedure

Allergies

Does the patient have any allergies? ❑ Yes ❑ No

Please list all known allergies: _____

_____

Medications

Does the patient currently take any medications? ❑ Yes ❑ No

Please list all medications being taken: _____

_____

Other Information

Please use this section to describe any other significant health history issues that you would like to make the doctor aware of: _____

_____

Form completed by: _____ _____

Print Name Relationship to patient

Signature: _____ Date (D/M/Y) _____