
# Dr. Tamzin Morley, ND

Phone: 778-471-0909
Address: #306-153 Seymour St., Kamloops, BC, V2C 2G2
Email: doctortamzin@gmail.com
Website: www.doctortamzin.com


**Health History Intake Form - PEDIATRIC:**

Care Card # (PHN): _____ Date: _____

First Name: _____ Last Name:_____

Gender: _____ Date of Birth (DD/MM/YY): _____ Age:_____

Address:_____

City:_____ Province:_____ Postal Code: _____

| Parents/Caregiver names | Mom/Caregiver | Dad/Caregiver |
|---|---|---|
| Home phone: | | |
| Work phone | | |
| Cell phone: | | |
| Email Address: | | |
| If needed, can the clinic contact you via email (circle): YES NO | | |

Emergency contact Name: _____ Phone:_____
Relationship:_____

How did you hear about Dr. Tamzin Morley: _____

Health Concerns:
1. _____
2. _____
3. _____
4. _____
5. _____

Medications (Prescription and Non-Prescription):_____
_____
Allergies (Medication, Food, Environmental):_____
_____
Supplements (Vitamins, Minerals, Herbs, etc): ):_____
_____
Past Procedures/Surgeries/Hospitalizations: (Description & Date):_____
_____
_____
_____

**Past Medical History** (P=Past, C=Current):

| Condition | P | C | Condition | P | C | Condition | P | C |
|---|---|---|---|---|---|---|---|---|
| Acne | | | Fatigue | | | Scarlet Fever | | |
| Allergies | | | Frequent Colds and Flu | | | Skin Disease | | |
| Anemia | | | Headache | | | Sinusitis | | |
| Bed wetting | | | Heart murmur | | | Strep Throat | | |
| Birth defects | | | High Fever | | | Stuffy nose | | |
| Cancer | | | Hyperactivity | | | Thrush | | |
| Chicken Pox | | | Insomnia | | | Tonsilitis | | |
| Colic | | | Jaundice | | | | | |
| Cold Sores | | | Learning Disorder | | | Tuberculosis | | |
| Constipation | | | Low/High BP | | | Typhoid Fever | | |
| Cough/wheezing | | | Malaria | | | Vomiting spells | | |
| Cradle Cap | | | Mononucleosis | | | Warts | | |
| Depression | | | Moodiness | | | Whooping Cough | | |
| Diarrhea | | | Mumps | | | Worms | | |
| Dizzy Spells | | | Parasites | | | Other: | | |
| Earaches/Infections | | | Pneumonia | | | | | |
| Exposure to cigarette smoke | | | Rheumatic Fever | | | | | |
| Epilepsy/seizures | | | Rubella | | | | | |

| Immunization | Age given | Any Adverse Reactions? |
|---|---|---|
| DPT (Diptheria, Pertussis, Tetanus) | | |
| MMR (Measles, Mumps, Rubella) | | |
| Polio | | |
| Haemophilus Influenza Type B (Meningitis) | | |
| Hep-B (Hepatitis B) | | |

**Family Medical History** (Blood Relatives, NOT including your child):

| | Which Relative and Age of Onset? | Doctors notes |
|---|---|---|
| □ Cancer | | |
| □ Diabetes | | |
| □ Heart Attack | | |
| □ Stroke | | |
| □ Seizures/Epilepsy | | |
| □ High Blood Pressure | | |
| □ Asthma | | |
| □ Hearing Loss | | |
| □ Allergies | | |

| | Which Relative and Age of Onset? | Doctors notes |
|---|---|---|
| □ Addiction | | |
| □ Hepatitis | | |
| □ Gout | | |
| □ Obesity | | |
| □ Osteoporosis | | |
| □ Arthritis | | |
| □ Thyroid Disease | | |
| □ Kidney Disease | | |
| □ Depression/Anxiety | | |
| □ Colon Cancer | | |
| □ Breast Cancer | | |
| □ Uterine Cancer | | |
| □ Ovarian Cancer | | |
| □ Other Cancer (list): | | |

**Lifestyle and Social History:**

| Parents/Caregivers: | Married Separated Divorced | Doctor's notes |
|---|---|---|
| Mother/Caregiver occupation: | | |
| Father/Caregiver occupation: | | |
| # of Siblings | | |
| Daycare/Preschool: | Hrs per day?: Hrs per week?: | |
| Regular Exercise?: | Type?: | |

| Social | Yes | No | Details | Doctor's notes |
|---|---|---|---|---|
| Interacts well with others? | | | | |
| Good social network? | | | Who? | |

| Lifestyle: | Yes | No | Details |
|---|---|---|---|
| Does your child feel stressed? | | | Level (circle): Low Medium High |
| Source of stress? | | | |
| What does your child do to relieve stress?: | | | |

| Sleep: | Yes | No | Details |
|---|---|---|---|
| Problems falling asleep? | | | |
| Problems staying asleep? | | | |
| Wake up feeling rested? | | | # hours sleep per night?: |
| Does your child dream? | | | |

| Diet | Details |
|---|---|
| Does your child follow a particular diet? | |
| Known food allergies/intolerances? | |
| What is your childs typical breakfast? | |
| What is your childs typical lunch? | |
| What is your childs typical dinner? | |
| How much water does your child drink per day? | |
| What is your childs current weight? | |

| | |
|---|---|
| What was your childs weight one year ago? | |
| What is your childs height? | |

Prenatal/Birth/Feeding History:

<table>
<tr><td>Mothers health during pregnancy:<br><table><tr><td>Age:</td><td>Medications:</td></tr><tr><td>Bleeding:</td><td>X-Rays:</td></tr><tr><td>Nausea:</td><td>Smoking:</td></tr><tr><td>Stress:</td><td>Alcohol consumption:</td></tr><tr><td>Trauma/Injury:</td><td>Recreational drug use:</td></tr><tr><td>High Blood Pressure:</td><td>Other:</td></tr></table></td><td>Doctor’s notes</td></tr>
<tr><td>Term:<br>Preterm:_____ Full term :_____ Birth Weight:_____</td><td></td></tr>
<tr><td>Pregnancy/Labour and Delivery:<br>Easy: _____ Difficult:_____ Vaginal:_____ C-Section:_____</td><td></td></tr>
<tr><td>Feeding of infant:<br>Breast fed:_____ how long?:_____<br>Formula fed:_____ how long?: _____ Type of formula: _____<br>Age solid food was introduced:<br>Any cow’s milk introduced:</td><td></td></tr>
</table>