*109-525 Belmont Avenue W.*
*Kitchener, ON, N2M 5E2*
*226.791.9168*

Child's legal name: _____
Preferred name & pronouns: _____
Date of birth (MM/DD/YYYY): _____

# Pediatric Medicosocial and Dental Questionnaire

Rev. 0п/202н

Does your child have any of the following conditions?

Please check all conditions that apply.

- ❒ Low blood counts that require child to wear a mask
- ❒ Persistent cough greater than 3 weeks OR a cough that produces blood
- ❒ Been exposed to or have Tuberculosis

Who is your child's primary medical doctor? _____

Primary Medical Doctor Address _____Phone: _____

- ❒ My child received care in the last year for a medical, emotional, developmental, or behavioral condition
- ❒ My child had surgery or operations, emergency department visits, or overnight stays in the hospital

Please provide details about hospitalization(s):

_____

_____

_____

- ❒ My child is vaccinated against common childhood infections
- ❒ My child is currently pregnant

Does your child have a past history or a current disease, problem, or condition involving any of the following?

- ❒ Behavior/Emotions/Mental health
- ❒ Birth Defects/Syndrome
- ❒ Blood/Bleeding
- ❒ Bones/Joints/Connective Tissues
- ❒ Brain/Spinal Cord
- ❒ Complications Before/During Birth
- ❒ Intellectual/Developmental Disabilities
- ❒ Eating/Swallowing/Nutrition/Digestion
- ❒ Exercise/Body Movement
- ❒ Head/Eyes/Ears/Nose/Throat
- ❒ Hormones/Pregnancy
- ❒ Heart/Blood Vessels
- ❒ Height/Weight
- ❒ Infections/Immune System
- ❒ Kidneys/Urinary Tract
- ❒ Liver/Stomach/Intestines
- ❒ Lungs/Airway/Breathing
- ❒ Muscles/Nerves/Reflexes
- ❒ Sensory problems
- ❒ Speech/Language
- ❒ Skin/Glands

Please describe the checked condition(s) above or provide information about any disease or condition not listed above

- ❒ My child has allergies or develops a reaction to medications, foods, or environmental allergens

Please specify: _____

_____

- ❒ My child takes medications, diet supplements, vitamins, or natural or herbal products

Please specify: _____

_____

**Family**

Who does your child live with?

Who is your child's legal guardian?

**Education/Occupation**

Does your child go to school or daycare?

What school grade is your child in?

**Transportation**

What is your primary mode of transportation?

**Race and Ethnicity**

What race/ethnicity does your child identify with?

What is your child's preferred language?

Date of last dental x-rays

How often does your child brush?

How often does your child floss?

Date of last dental treatment:

Date of last teeth cleaning:

Reason for today's dental visit:

Other dental concerns:

**********

To the best of my knowledge, this medicosocial and dental form is complete and correct.

Name of legal guardian and relationship to patient

Signature of legal guardian

Date