



NEW PATIENT QUESTIONNAIRE

Mother's Name _____ Age _____

Occupation _____

Father's Name _____ Age _____

Occupation _____

If adults in the household work outside the home, what child care arrangements are made for this child? _____

A. PREGNANCY AND BIRTH

- Mother's age at birth _____
- Did mother have any illness during pregnancy? No Yes
- Did she take any medications other than vitamins/Iron? No Yes
- Was the baby on time? Yes No
- What was the birthweight? _____
- Did the baby have any trouble starting to breathe? No Yes
- Did the baby have any trouble while in the hospital? No Yes
(Jaundice, infections, other?)
What kind? _____

B. PAST MEDICAL HISTORY

- Where has your child gone for check-ups until now? _____
- Date of last check-up: _____
- Date of last dental check-up? _____
- Has your child had reactions to any medications, food or insect bites? No Yes
- Has your child had reactions to any immunizations? No Yes
Which ones? _____
- Any hospitalizations other than for birth? No Yes
For what? _____
- Any serious injuries? No Yes
What kind? _____
- Are any medications taken regularly? No Yes
Which ones? _____

C. FAMILY HISTORY

- Are the child's parents both in good health? Yes No
- Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts or uncles have had:
Anemia, Asthma, Allergies, Diabetes, High Blood Pressure, Heart Trouble, Tuberculosis, Mental Illness, Drug Problems, Alcohol Problems, AIDS, Inherited Illness, Cancer, STD, Others _____
- List age, sex and general health of brothers and sisters _____

- Have any of your children died? No Yes

D. FEEDING AND NUTRITION

- Is your child's appetite usually good? Yes No
- Is it good now? Yes No
- Was there severe colic or any unusual feeding problems during the first 3 months? Yes No
- Do any foods disagree with him/her? No Yes
- For the first 6 months, is/was he/she breastfed or bottlefed? (Circle One)

Patient's Name _____

Date of Birth _____

- If still on formula, which one do you use? _____
- Does he/she take vitamins? Yes No

E. REVIEW OF SYSTEMS

- Has your child had frequent ear infections? No Yes
- Any eye problems? No Yes
- Has he/she had any problems with teeth? No Yes
- Does he/she have frequent colds/sore throats? No Yes
- Is there asthma, pneumonia or recurrent cough? No Yes
- Does he/she have a heart murmur or any heart problems? No Yes
- Any problems with urination? No Yes
- Any problems with diarrhea or constipation? No Yes
- Have there been any convulsions or other problems with the nervous system? No Yes
- Any eczema, hives or other conditions? No Yes
- Has your child ever been anemic? No Yes
- Please list any other medical problems _____

F. DEVELOPMENT/BEHAVIOR

- At what age did your child sit alone? _____
- At what age did he/she walk alone? _____
- Did he/she say any words by the time he/she was 1 1/2 years old? Yes No
- How does this child compare to other his or her own age? _____
- Does he/she have any trouble sleeping? No Yes
- What grade is he/she in? _____
- Has he/she had any trouble in school? No Yes
- Does he/she get along with other children? Yes No
- Circle if you child has had any of the following:

Nail biting, thumb sucking, bedwetting, problems with toilet training, bad temper, hyperactivity, inattention, nightmares, speech problems, problems with discipline, others _____

G. SAFETY/ENVIRONMENT

- Do you live in a private house, apartment, mobile home, other? (Circle One)
- Do you know the hottest temperature of the water in your pipes? Yes No
- Is there a working smoke alarm on each floor of the house? Yes No
- Does your child always use a car seat/seat belt when riding in a car? Yes No
- Are there smokers in the household? Yes No
- Are there any problems with the condition of your home? (Peeling paint, insects, rats, mice) Yes No
- Does your child always wear a helmet when riding his/her bicycle? Yes No

H. IMMUNIZATIONS

- Do you have a record of immunizations for this child? Yes No