

New Patient Questionnaire

Patient's name: _____

Today's Date: _____

Date of Birth: _____

Mother's name: _____

Occupation: _____

Father's Name: _____

Occupation: _____

Pregnancy and Birth

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than Vitamins and iron? No Yes
4. Was the baby born earlier than the due date? No Yes
If yes, by how many weeks? _____
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, feeding, etc.) No Yes
What kind? _____

Family History

1. Are the child's parents both in good health No Yes
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies, cancer, cystic fibrosis, heart trouble, tuberculosis, inherited illness, seizures, sudden deaths, others?
3. Have any of your children died? No Yes

Past Medical History

1. Where has your child gone for check-ups until now? _____
2. Date of last check-up _____
3. Date of last dental check-up _____
4. Has your child had allergic reactions to any medications, foods, or insect bites? No Yes
Which ones? _____
5. Has your child had reactions to any immunizations? No Yes
Which ones? _____
6. Any hospitalizations other than for birth? No Yes
For what? _____
7. Any serious injuries? No Yes
What kind? _____
8. Are any medications taken regularly? No Yes
Which ones? _____

Social History

1. List age, gender, and general health condition of brothers and sisters:

2. List household members:

3. List any type of household pets:

4. Does your child attend day care? No Yes
If yes, how many days per week _____
5. Are there any smokers in the household? No Yes

Feeding and Nutrition

1. Is your child's appetite usually good? Yes No
2. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
3. Do any foods disagree with him/her? No Yes
4. During the first 12 months, is he/she (was he/she) breast-fed or bottle-fed? _____

Review of systems:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problems:

Safety

1. Do you live in a private house, apartment, mobile home, other? (circle one)
2. Is there a working smoke alarm on each floor in the house? Yes No
3. Does your child always use a car seat/seat belt when riding in a car? Yes No
4. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) No Yes
5. Does your child always wear a helmet when riding his/her bicycle and protective gear when roller-blading or roller-skating? Yes No

Transfer of Medical Records

1. Have you arranged to have your child's medical and/or hospital records transferred to this office? Yes No
2. Did you bring a copy of your child's Immunization records? Yes No