

NEW PATIENT QUESTIONNAIRE
(to be filled out by Patient or Legal Guardian)

DATE: _____

Patient's Name: _____ D. O. B. _____

Address: _____

Mother's Name: _____ Age: _____

Address: _____

Occupation: _____

Father's Name: _____ Age: _____

Address: _____

Occupation: _____

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

(PLEASE CHECK APPROPRIATE ANSWER)

A. PREGNANCY AND BIRTH	Yes	No	Comments
Mother's age at birth of child?			
Did mother have any illness during pregnancy?			
Did she take any medications other than vitamins or iron?			
Was the baby born on time?			
What was the baby's weight?			
Did the baby have trouble starting to breathe?			
Did the baby have any trouble while in the hospital? (jaundice, infections, other)			

B. PAST MEDICAL HISTORY	Yes	No	Comments
Where has your child gone for checkups until now?			
Date of last checkup?			
Date of last dental checkup?			
Has your child had any allergic reactions to any medications, food, insect bites? (If so, which ones?)			
Has your child had any reactions to immunizations? (If so, which ones?)			
Any hospitalizations other than that for birth? (If so, give reason)			
Any serious injuries?			
Are any medications taken regularly? Which ones?			
Operations?			

C. FAMILY HISTORY	Yes	No	Comments
Are both child's parents in good health?			

Circle any diseases that this child's parents, grandparents, siblings, aunts and uncles may have had.

Anemia	Asthma	Allergies	Diabetes	High Blood Pressure	Heart Trouble	Tuberculosis	Mental Health
Drug Problems	Alcohol Problems	Inherited Illness	Venereal disease	Cancer	Aids	Other: _____	

List Age, sex and general health of brothers/sisters

	Age	Sex	Health
1.			
2.			
3.			
4.			

D. FEEDING AND NUTRITION

	Yes	No	Comments
Is your child's appetite usually good?			
Is it now?			
Was there severe colic or any unusual feeding problems during the first 3 months?			
Do any foods disagree with him/her?			
For the first 6 mos. Is he/she (was he/she) breast or bottle fed?			
If still on formula, which one do you use?			
Does he/she take vitamins?			

E. REVIEW OF SYSTEMS

	Yes	No	Comments
Does your child get frequent ear infections?			
Any eye problems?			
Has he/she had any problems with teeth?			
Does he/she have frequent colds or sore throats?			
Is there asthma, pneumonia or recurrent cough?			
Does he/she have a heart murmur or any heart problems?			
Any type of kidney or bladder problems?			
Any problems with diarrhea or constipation?			
Have there been any convulsions or other problems with the nervous system?			
Any eczema, hives or other skin conditions?			
Has your child ever been anemic?			
Has any family member or your child been diagnosed with diabetes?			
Exposed to T.B.?			
Any type of orthopedic (bone) disorders?			

Please list any other medical problems: _____

F. DEVELOPMENT/BEHAVIOR

	Yes	No	Comments
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 1½ yrs old?			
How does he/she compare to others his or her age? (circle one) Appropriate Inappropriate			
Does he/she have trouble sleeping?			
What grade is he/she in?			
Has he/she had any trouble in school?			
Does he/she get along with other children?			

G. SAFETY/ENVIRONMENT

	Yes	No	Comments
Do you live in a home apartment mobile home other? (Please circle one)			
Do you know the hottest temperature of the water in your pipes?			
Is there a working smoke alarm on each floor in the house?			
Does your child always use a car seat/seat belt when riding in the car?			
Are there any smokers in the household?			
Are there any problems with the condition of your home? (insects, rodents, chipped or peeling paint)			
Does your child always wear a helmet when riding his/her bike?			

H IMMUNIZATIONS

	Yes	No	Comments
Do you have a record of immunizations?			