New Patient Questionnaire

Child's Name

Mother's Name

Occupation

Mother's Date of Birth_____

Father's Name

Occupation

Father's Date of Birth_____

Child care arrangements

Are parents: Married?
Divorced? Living Apart?
(circle one)

Pregnancy and Birth:

1. Did mom have any illness during the pregnancy? No Yes

2. Did mom take any medications during the pregnancy?
No Yes

3. Was your baby on time?
Yes No

4. What was the birthweight?
_____

5. Did your baby spend any time in the NICU?
No Yes

Past Medical History:

1. Has child had check up in the last 12 months?	Yes	No
2. Has child had dental exam in last 12 months?	Yes	No
3. Any allergic reactions to meds, food, insects?	No	Yes
If yes, which ones?_____		
4. Any reactions to immunizations?	No	Yes
If yes, which ones?_____		
5. Any hospitalizations other than at birth?	No	Yes
6. Any serious injuries?	No	Yes
If yes, what kind?_____		

Family History:

1. Are the child's parents in good health? Yes No
2. Circle any diseases that run in the family:

Anemia	asthma	allergies
Diabetes	high blood pressure	heart disease
Tuberculosis	mental illness	drug addiction
Alcohol addiction	venereal disease	cancer AIDS

Development/Behavior:
(don't need to answer if newborn)

1. Is development normal until now?	Yes	No
2. Any sleep problems?	No	Yes
3. What grade is child in?	_____	
4. Any trouble or difficulty in school?	No	Yes
5. Does your child get along with other children?	Yes	No

Safety/Environment:

1. Do you live in a:	House apartment	other
2. Do you know the water temp in pipes?	Yes	No
3. Is there a smoke alarm on each floor?	Yes	No
4. Do you always use a car or booster seat?	Yes	No
5. Do children always ride in back seat?	Yes	No
6. Any smokers in the house?	No	Yes
7. Any guns in the house?	No	Yes
8. Any physical, verbal, or sexual abuse in house?	No	Yes

Tests/Immunizations:

1. Has child received all recommended vaccines?	Yes	No
2. Are you against vaccinating your child?	No	Yes
3. Has your child been tested for anemia?	Yes	No
4. Has your child been tested for lead exposure?	Yes	No

Review of Systems:

1. Does your child get frequent ear infections?	No	Yes
2. Any eye or vision problems?	No	Yes
3. Any teeth problems?	No	Yes
4. Any history of asthma or recurrent cough?	No	Yes
5. Any heart murmurs or heart disease?	No	Yes
6. Any problem with urination?	No	Yes
7. Any diarrhea or constipation?	No	Yes
8. Any history of seizures or neurologic problems?	No	Yes
9. Any eczema, hives, or other skin problems?	No	Yes
10. Any history of anemia?	No	Yes