

Name _____
 Chart # _____
 Date _____
 Reviewed _____

New Patient Questionnaire:

If both parents in the household work outside the home, what are the child care arrangements for this child?

A. Pregnancy and Birth:

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? YES NO
3. Did she take medications other than iron or vitamins? YES NO
4. Was the baby on time? YES NO
5. What was the birth weight? _____
6. Did the baby have trouble starting to breathe? YES NO
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other) YES NO

B. 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, insect bites? YES NO
5. Has your child had any reactions to immunizations? YES NO
6. Has your child ever been hospitalized (other than birth)? YES NO
7. Has your child had any serious injuries? YES NO
8. Does your child take medication regularly? YES NO

C. Family History:

1. Are the child's parents in good health? YES NO
2. 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, inherited illness, venereal disease, cancer, AIDS, other.

3. List age, sex and general health of child's brothers and sisters.

4. Have any of your children died? YES NO

D. Feeding and Nutrition:

1. Is your child's appetite usually good? YES NO
2. Is it good now? YES NO
3. Was there severe colic or any unusual feeding problem during the first 3 months? YES NO
4. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? _____
5. If still on formula, which one do you use? _____
6. Does your child take vitamins? YES NO

E. Review of Systems:

1. Circle any of the following problems your child has had: frequent ear infections, eye problems, teeth problems, frequent colds or sore throats, asthma, pneumonia, recurrent cough, heart murmur, heart problems, problems urinating, diarrhea, constipation, convulsions, problems with nervous system, eczema, hives, other skin conditions, anemia, other medical problems.

F. Development/Behavior:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1 1/2 years old? YES NO
4. How does this child compare to others his/her age? _____
5. Does he/she have any trouble sleeping? YES NO
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? YES NO
8. Does he/she get along with others? YES NO
9. Circle if your child has had any of the following: Nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others.

G. Safety/Environment:

1. Do you know the hottest temperature of the water in your pipes? YES NO
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 smokers in the house? YES NO
5. Are there any problems with the condition of your home? (peeling paint, insects, rats or mice)? YES NO
6. Does your child always wear a helmet when riding his/her bicycle? YES NO

H. Immunizations:

1. Do you have a record of immunizations? YES NO
2. Is your child up to date on immunizations? YES NO