NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PARENT

NAME: _____
CHART#: _____
DATE: _____
(OFFICE USE ONLY)

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:

1. Mother's age at birth. _____
2. Did mother have any illness during pregnancy? Yes No
3. Did she take any medications other than vitamins and iron? Yes No
4. Was the baby born on time? Yes No
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breathe? Yes No
7. Did the baby have any trouble while in the Hospital? Yes No
   (jaundice, infections, other?) If so, please explain: _____

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? Yes No
   Foods? Insect bites? Which ones? _____
5. Has your child had reactions to any immunizations? Yes No
   Which ones? _____
6. Any hospitalizations other than for birth? Yes No
   For what? _____
7. Any serious injuries? Yes No
   What kind? _____
8. Are any medications taken regularly? Yes No
   Which ones? _____

C. FAMILY HISTORY:

1. Are the child's parents both 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, others:
3. List Age, Sex and general Health of 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 problems during the first 3 months after the child was born? Yes No
4. Do any foods disagree with him / her? Yes No
5. For the first 6 months was your child breast fed or bottle fed?
   _____Breast fed _____Bottle fed
6. If your child is presently on formula which one do you use?

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? Yes No
2. Any eye problems? Yes No
3. Any problems with the child's teeth? Yes No
4. Frequent colds or sore throats? Yes No
5. Asthma, pneumonia or recurrent cough? Yes No
6. Heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
12. Please list any other medical problems: _____

F. DEVELOPMENT / BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did your child say any words by the age of 1 1/2 years old? Yes No
4. How does this child compare to others the same age?
5. Does the child have any trouble sleeping? Yes No
6. What grade is the child presently in? _____
7. Has the child had any trouble in school? Yes No
8. Does the child get along with other children? 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 live in a private house, apartment, mobile home, other? (PLEASE CIRCLE) Yes No
2. Do you know the hottest temperature of water in your pipes? Yes No
3. Is there a working smoke alarm on each floor in your home? Yes No
4. Does your child always use a car seat / seat belt when riding in a car? Yes No
5. Are there smokers in the household? Yes No
6. Are there any problems with the condition of your home? (Peeling paint, insects, rats or mice?) Yes No
7. Does your child always wear a helmet when riding a bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No