NEW PATIENT QUESTIONNAIRE

PATIENT'S (CHILD) NAME: _____DATE OF BIRTH:_____SEX:_____

YOUR NAME: _____RELATIONSHIP TO CHILD:_____

AGE:_____ OCCUPATION:_____WHERE DO YOU LIVE: CITY_____COUNTY_____

HOW LONG HAS THE CHILD BEEN IN YOUR CARE?:_____PHONE:_____

OTHER PARENT'S NAME:_____AGE:_____OCCUPATION:_____

WHO LIVES IN THE HOME WITH CHILD? NUMBER OF ADULTS: _____NUMBER OF CHILDREN: _____

PLEASE LIST NAME AND AGES OF PATIENT'S BROTHERS AND SISTERS

NAME: _____AGE:_____ NAME: _____AGE:_____

NAME: _____AGE:_____ NAME: _____AGE:_____

PETS: _____ TYPE OF HOME: APARTMENT ☐ TRAILER ☐ HOUSE ☐

SMOKERS IN HOUSEHOLD: YES ☐ NO ☐ WHO: _____

WATER SOURCE: CITY ☐ COUNTY ☐ WELL ☐ BOTTLED ☐

MEDICAL HISTORY

PREGNANCY HISTORY:

DID PATIENT'S MOTHER USE ANY OF THE FOLLOWING SUBSTANCES, OR HAD ANY OF THE FOLLOWING SYMPTOMS DURING PREGNANCY?:

	Y	N	DON'T KNOW	DOCTOR'S NOTES
MEDICATION (PLEASE NAME):				
STREET DRUGS (PLEASE NAME):				
ALCOHOL				
SMOKING				
VAGINAL INFECTION: GC CHLAMYDIA HERPES				
GROUP B STREP INFECTION				
OTHER PROBLEMS:				

BIRTH HISTORY:

	DOCTOR'S NOTES
HOW LONG WAS THE PREGNANCY: _____WEEKS	
NAME OF HOSPITAL BABY WAS BORN AT:	
WHAT WAS THE BABY'S BIRTH WEIGHT:	
HOW LONG DID THE BABY STAY IN THE HOSPITAL:	
WAS THE DELIVERY … VAGINAL ☐ C SECTION ☐	
DID THE BABY HAVE ANY PROBLEMS: Y ☐ N ☐ DON'T KNOW ☐	
DID YOUR BABY PASS THE HEARING SCREEN?	
DID YOUR BABY RECEIVE THE HEPATITIS B VACCINE?	

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MEDICAL HISTORY (CONT'D)

DOES PATIENT (CHILD) HAVE A CHRONIC MEDICAL CONDITION OR OTHER ISSUE TO BE AWARE OF? _____

_____

FAMILY HISTORY: **(CHECK IF ANY CLOSE BLOOD RELATIVES HAVE THE FOLLOWING)**

DISEASE	Y	N	WHO	DISEASE	Y	N	WHO
ASTHMA				HEART ATTACK <55 YRS.			
SICKLE CELL DISEASE				ECZEMA			
CYSTIC FIBROSIS				HAYFEVER/SEASONAL ALLERGIES			
KIDNEY ABNORMALITIES				HIGH BLOOD PRESSURE			
URINARY TRACT INFECTIONS				ANEMIA/BLOOD PROBLEMS			
DIABETES				LEARNING PROBLEMS			
HYPERACTIVITY				SEIZURES			
MENTAL RETARDATION				EMOTIONAL PROBLEMS			
SUDDEN DEATH				BORN WITH HEART PROBLEMS			
BIRTH DEFECTS				DEATH SHORTLY AFTER BIRTH			
OTHER SIGNIFICANT HISTORY: _____				CHRONIC EAR INFECTIONS			

----------**********STOP HERE IF PATIENT IS A NEWBORN**********----------

	Y	N	DON'T KNOW	DOCTOR'S NOTES
ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE?				
HAS YOUR CHILD EVER BEEN HOSPITALIZED OVERNIGHT?				
HAS YOUR CHILD EVER HAD SURGERY?				
DOES YOUR CHILD HAVE ANY ALLERGIES? TO WHAT?				
DOES YOUR CHILD GET REGULAR MEDICATIONS? PLEASE LIST:				
HAS YOUR CHILD GONE TO THE ER THIS PAST YEAR?				
HAS YOUR CHILD EVER HAD: EAR INFECTIONS				
MORE THAN 2 STREP THROATS				
PNEUMONIA				
HEART PROBLEMS				
CHICKENPOX				
ANY MAJOR ILLNESS				
REACTION TO ANY IMMUNZATION OR MEDICATIONS				
URINARY TRACT INFECTION				
WHEEZING				

SCHOOL/DAYCARE BEHAVIOR HISTORY:

NAME OF CHILD'S SCHOOL:_____**GRADE:**_____

	Y	N	DON'T KNOW	DOES NOT APPLY
DOES YOUR CHILD ATTEND SPECIAL CLASSES, OR RECEIVE SPECIAL HELP?				
ARE YOU CONCERNED ABOUT SCHOOL BEHAVIOR PROBLEMS?				
DOES YOUR CHILD HAVE PROBLEMS WITH: FREQUENT NIGHTMARES				
DIFFICULT TO CONTROL				
FIGHTING A LOT				
TROUBLE MAKING FRIENDS				
BEDWETTING OR STOOLING PROBLEMS				
VISION/HEARING				
APPETITE				

NAME OF CHILD'S PREVIOUS DOCTOR:_____

ADDRESS AND PHONE NUMBER:_____

ARE THERE ANY SPECIFIC ISSUES YOU WOULD LIKE TO DISCUSS WITH YOUR DOCTOR:_____

_____

_____

SIGNATURE OF PARENT COMPLETING THIS FORM **DATE**

THANK YOU VERY MUCH!

REVIEWED BY DOCTOR:_____